



# **Commonwealth of Kentucky KY Medicaid**

## **Provider Billing Instructions For Psychiatric Residential Treatment Facility Services Provider Type – 04**

Version 4.1

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## Document Change Log

Document Version	Date	Name	Comments
1.0	10/26/2005	HP Enterprise Services	Initial creation of DRAFT Psychiatric Residential Treatment Facility – PT04
1.1	12/12/2005	HP Enterprise Services	Incorporate revisions from Commonwealth.
1.2	01/18/2006	HP Enterprise Services	Replace Provider Rep list with current list.
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1.6	09/18/2006	Ann Murray	Replaces Provider Representative table.
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# 1 General

## 1.1 Introduction

These instructions are intended to assist persons filing claims for services provided to Kentucky Medicaid Members. Guidelines outlined pertain to the correct filing of claims and do not constitute a declaration of coverage or guarantee of payment.

Policy questions should be directed to the Department for Medicaid Services (DMS). Policies and regulations are outlined on the DMS website at:

<http://chfs.ky.gov/dms/Regs.htm>

Fee and rate schedules are available on the DMS website at:

<http://chfs.ky.gov/dms/fee.htm>

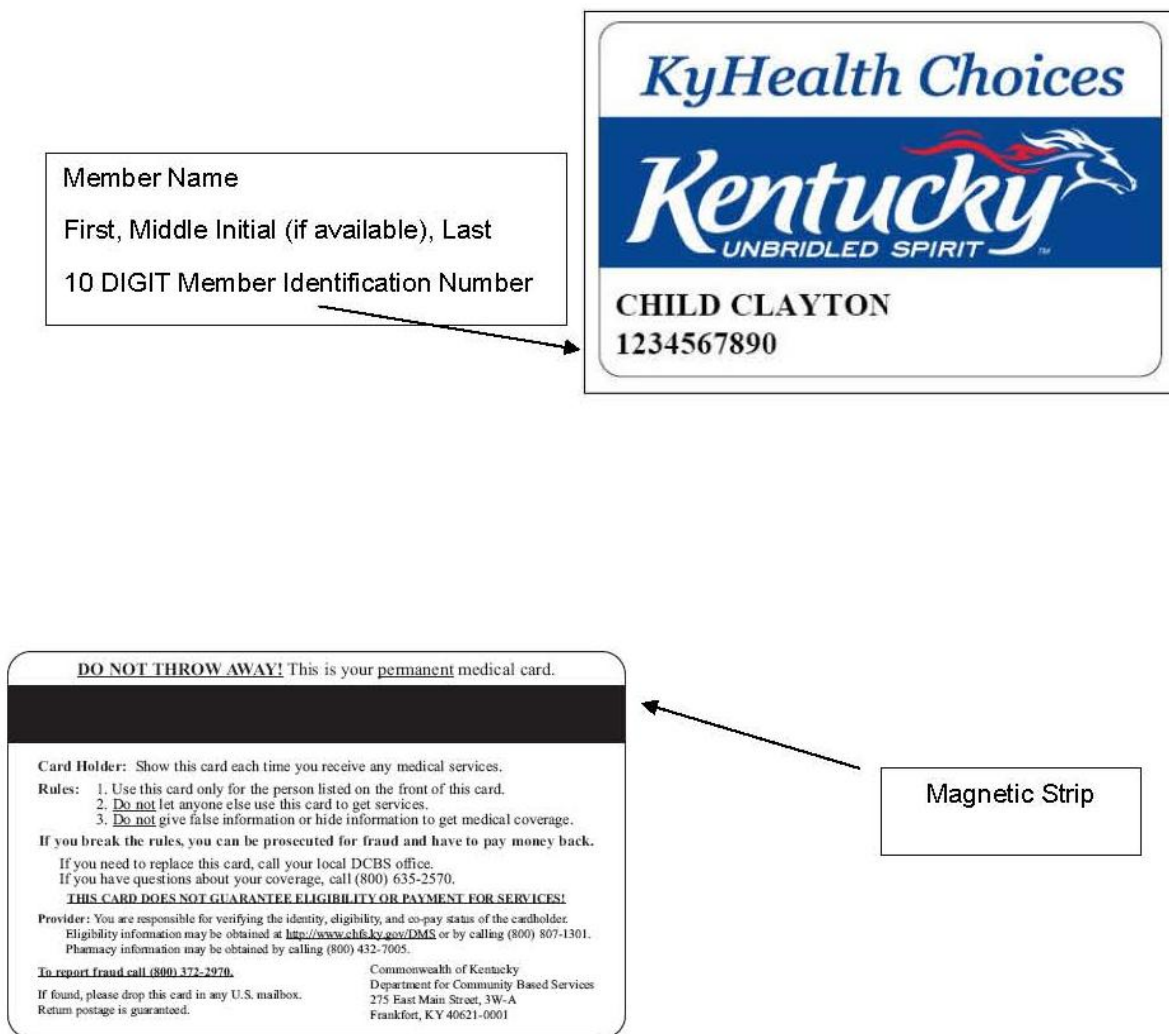
## 1.2 Member Eligibility

Members should apply for Medicaid eligibility through their local Department for Community Based Services (DCBS) office. Members with questions or concerns can contact Member Services at 1-800-635-2570, Monday through Friday. This office is closed on Holidays.

The primary identification for Medicaid-eligible members is the Kentucky Medicaid card. This is a permanent plastic card issued when the Member becomes eligible for Medicaid coverage. The name of the member and the member's Medicaid ID number are displayed on the card. The provider is responsible for checking identification and verifying eligibility before providing services.

**NOTE: Payment cannot be made for services provided to ineligible members; and possession of a Member Identification card does not guarantee payment for all medical services.**

### 1.2.1 Plastic Swipe KY Medicaid Card



Through a vendor of your choice, the magnetic strip can be swiped to obtain eligibility information.

Providers who wish to utilize the card's magnetic strip to access eligibility information may do so by contracting with one of several vendors.



## 1.2.2 Member Eligibility Categories

### 1.2.2.1 QMB and SLMB

Qualified Medicare Beneficiaries (QMB) and Specified Low-Income Medicare Beneficiaries (SLMB) are Members who qualify for both Medicare and Medicaid. In some cases, Medicaid may be limited. A QMB Member's card shows "QMB" or "QMB Only." QMB Members have Medicare and full Medicaid coverage, as well. QMB-only Members have Medicare, and Medicaid serves as a Medicare supplement only. A Member with SLMB does not have Medicaid coverage; Kentucky Medicaid pays a "buy-in" premium for SLMB Members to have Medicare, but offers no claims coverage.

### 1.2.2.2 Managed Care Partnership

Passport is a healthcare plan serving Kentucky Medicaid members who live in the following counties: Breckinridge, Bullitt, Carroll, Grayson, Hardin, Henry, Jefferson, Larue, Marion, Meade, Nelson, Oldham, Shelby, Spencer, Trimble, and Washington.

The other Managed Care Plans servicing Kentucky Medicaid members are WellCare of Kentucky, Kentucky Spirit Health Plan and CoventryCares of Kentucky. These plans are not county regional as Passport indicated above.

Medical benefits for persons whose care is overseen by an MCO are similar to those of Kentucky Medicaid, but billing procedures and coverage of some services may differ. Providers with Managed Care plan questions should contact: Passport Provider Services at 1-800-578-0775, WellCare of Kentucky at 1-877-389-9457, Kentucky Spirit Health Plan at 1-866-643-3153 and CoventryCares of Kentucky at 1-855-300-5528.

### 1.2.2.3 KCHIP

The Kentucky Children's Health Insurance Program (KCHIP) provides coverage to children through age 18 who have no insurance and whose household income meets program guidelines. Children with KCHIP III are eligible for all Medicaid-covered services except Non-Emergency Transportation and EPSDT Special Services. Regular KCHIP children are eligible for all Medicaid-covered services.

For more information, access the KCHIP website at <http://kidshealth.ky.gov/en/kchip>.

### 1.2.2.4 Presumptive Eligibility

Presumptive Eligibility (PE) is a program which offers pregnant women temporary medical coverage for prenatal care. A treating physician may issue an Identification Notice to a woman after pregnancy is confirmed. Presumptive Eligibility expires 90 days from the date the Identification Notice is issued, but coverage will not extend beyond three calendar months. This short-term program is only intended to allow a woman to have access to prenatal care while she is completing the application process for full Medicaid benefits.

#### 1.2.2.4.1 Presumptive Eligibility Definitions

Presumptive Eligibility (PE) is designed to provide coverage for ambulatory prenatal services when the following services are provided by approved health care providers.

#### A. SERVICES COVERED UNDER PE

- Office visits to a Primary Care Provider (see list below) and/or Health Department
- Laboratory Services

- Diagnostic radiology services (including ultrasound)
- General dental services
- Emergency room services
- Transportation services (emergency and non-emergency)
- Prescription drugs (including prenatal vitamins)

**B. DEFINITION OF PRIMARY CARE PROVIDER – Any health care provider who is enrolled as a KY Medicaid provider in one of the following programs:**

- Physician/osteopaths practicing in the following medical specialties:
  - Family Practice
  - Obstetrics/Gynecology
  - General Practice
  - Pediatrics
  - Internal Medicine
- Physician Assistants
- Nurse Practitioners/ARNP's
- Nurse Midwives
- Rural Health Clinics
- Primary Care Centers
- Public Health Departments

**C. SERVICES NOT COVERED UNDER PE**

- Office visits or procedures performed by a specialist physician (those practicing in a specialty other than what is listed in Section B above), even if that visit/procedure is determined by a qualified PE primary care provider to be medically necessary
- Inpatient hospital services, including labor, delivery and newborn nursery services;
- Mental health/substance abuse services
- Any other service not specifically listed in Section A as being covered under PE
- Any services provided by a health care provider who is not recognized by the Department for Medicaid Services (DMS) as a participating provider

**1.2.2.5 Breast & Cervical Cancer Treatment Program**

Breast and Cervical Cancer Treatment Program (BCCTP) offers Medicaid coverage to women who have a confirmed cancerous or pre-cancerous condition of the breast or cervix. In order to

qualify, women must be screened and diagnosed with cancer by the Kentucky Women's Cancer Screening Program, be between the ages of 21 to 65, have no other insurance coverage, and not reside in a public institution. The length of coverage extends through active treatment for the breast or cervical cancer condition. Those members receiving Medicaid through the Breast and Cervical Cancer Program are entitled to full Medicaid services. Women who are eligible through PE or BCCTP do not receive a medical card for services. The enrolling provider will give a printed document that is to be used in place of a card.

### **1.2.3 Verification of Member Eligibility**

This section covers:

- Methods for verifying eligibility;
- How to verify eligibility through an automated 800 number function;
- How to use other proofs to determine eligibility; and,
- What to do when a method of eligibility is not available.

#### **1.2.3.1 Obtaining Eligibility and Benefit Information**

Eligibility and benefit information is available to providers via the following:

- Voice Response Eligibility Verification (VREV) available 24 hours/7 days a week at 1-800-807-1301;
- KYHealth-Net at <http://www.chfs.ky.gov/dms/kyhealth.htm>
- The Department for Medicaid Services, Member Eligibility Branch at 1-800-635-2570, Monday through Friday, except Holidays.

##### **1.2.3.1.1 Voice Response Eligibility Verification (VREV)**

HP Enterprise Services maintains a Voice Response Eligibility Verification (VREV) system that provides member eligibility verification, as well as third party liability (TPL) information, Managed Care, PRO review, Card Issuance, Co-pay, provider check write, and claim status information.

The VREV system generally processes calls in the following sequence:

1. Greet the caller and prompt for mandatory provider ID.
2. Prompt the caller to select the type of inquiry desired (eligibility, check amount, claim status, and so on).
3. Prompt the caller for the dates of service (enter four digit year, for example, MMDDCCYY).
4. Respond by providing the appropriate information for the requested inquiry.
5. Prompt for another inquiry.
6. Conclude the call.

This system allows providers to take a shortcut to information. Users may key the appropriate responses (such as provider ID or Member number) as soon as each prompt begins. The number of inquiries is limited to five per call. The VREV spells the member name and

announces the dates of service. Check amount data is accessed through the VREV voice menu. The Provider's last three check amounts are available.

The telephone number (for use by touch-tone phones only) for the VREV is 1-800-807-1301. The VREV system cannot be accessed via rotary dial telephones.

#### 1.2.3.1.2 KYHealth-Net Online Member Verification

KYHEALTH-NET ONLINE ACCESS CAN BE OBTAINED AT:

<http://www.chfs.ky.gov/dms/kyhealth.htm>

The KyHealth Net website is designed to provide real-time access to member information. A User Manual is available for downloading and is designed to assist providers in system navigation. Providers with suggestions, comments, or questions, should contact the HP Enterprise Services Electronic Claims Department at [KY\\_EDI\\_Helpdesk@hp.com](mailto:KY_EDI_Helpdesk@hp.com).

All Member information is subject to HIPAA privacy and security provisions, and it is the responsibility of the provider and the provider's system administrator to ensure all persons with access understand the appropriate use of this data. It is suggested that providers establish office guidelines defining appropriate and inappropriate uses of this data.

## **2 Electronic Data Interchange (EDI)**

Electronic Data Interchange (EDI) is structured business-to-business communications using electronic media rather than paper.

### **2.1 How To Get Started**

All Providers are encouraged to utilize EDI rather than paper claims submission. To become a business-to-business EDI Trading Partner or to obtain a list of Trading Partner vendors, contact the HP Enterprise Services Electronic Data Interchange Technical Support Help Desk at:

HP Enterprise Services  
P.O. Box 2016  
Frankfort, KY 40602-2016  
1-800-205-4696

Help Desk hours are between 7:00 a.m. and 6:00 p.m. Monday through Friday, except holidays.

### **2.2 Format and Testing**

All EDI Trading Partners must test successfully with HP Enterprise Services and have Department for Medicaid Services (DMS) approved agreements to bill electronically before submitting production transactions. Contact the EDI Technical Support Help Desk at the phone number listed above for specific testing instructions and requirements.

### **2.3 ECS Help**

Providers with questions regarding electronic claims submission may contact the EDI Help desk.

### **2.4 Companion Guides for Electronic Claims (837) Transactions**

837 Companion Guides are available at:

<http://www.kymmis.com/kymmis/Companion%20Guides/index.aspx>

### **3 KyHealth Net**

The KyHealth Net website allows providers to submit claims online via a secure, direct data entry function. Providers with internet access may utilize the user-friendly claims wizard to submit claims, in addition to checking eligibility and other helpful functions.

#### **3.1 How To Get Started**

All Providers are encouraged to utilize KyHealth Net rather than paper claims submission. To become a KyHealthNet user, contact our EDI helpdesk at 1-800-205-4696, or click the link below.

<http://www.chfs.ky.gov/dms/kyhealth.htm>

#### **3.2 KyHealth Net Companion Guides.**

Field-by-field instructions for KyHealth Net claims submission are available at:

<http://www.kymmis.com/kymmis/Provider%20Relations/KYHealthNetManuals.aspx>

## **4 General Billing Instructions for Paper Claim Forms**

### **4.1 General Instructions**

The Department for Medicaid Services is mandated by the Centers for Medicare and Medicaid Services (CMS) to use the appropriate form for the reimbursement of services. Claims may be submitted on paper or electronically.

### **4.2 Imaging**

All paper claims are imaged, which means a digital photograph of the claim form is used during claims processing. This streamlines claims processing and provide efficient tools for claim resolution, inquiries, and attendant claim related matters.

By following the guidelines below, providers can ensure claims are processed as they intend:

- USE BLACK INK ONLY;
- Do not use glue;
- Do not use more than one staple per claim;
- Press hard to guarantee strong print density if claim is not typed or computer generated;
- Do not use white-out or shiny correction tape; and,
- Do not send attachments smaller than the accompanying claim form.

### **4.3 Optical Character Recognition**

Optical Character Recognition (OCR) eliminates human intervention by sending the information on the claim directly to the processing system, bypassing data entry. OCR is used for computer generated or typed claims only. Information obtained mechanically during the imaging stage does not have to be manually typed, thus reducing claim processing time. Information on the claim must be contained within the fields using font 10 as the recommended font size in order for the text to be properly read by the scanner.

## 5 Additional Information and Forms

### 5.1 Claims with Dates of Service More than One Year Old

In accordance with federal regulations, claims must be received by Medicaid no more than 12 months from the date of service, or six months from the Medicare or other insurance payment date, whichever is later. "Received" is defined in 42 CFR 447.45 (d) (5) as "The date the agency received the claim as indicated by its date stamp on the claim."

Kentucky Medicaid includes the date received in the Internal Control Number (ICN). The ICN is a unique number assigned to each incoming claim and the claim's related documents during the data preparation process. Refer to Appendix A for more information about the ICN.

For claims more than 12 months old to be considered for processing, the provider must attach documentation showing timely receipt by DMS or HP Enterprise Services and documentation showing subsequent billing efforts, if any.

To process claims beyond the 12 month limit, you must attach to each claim form involved, a copy of a Claims in Process, Paid Claims, or Denied Claims section from the appropriate Remittance Statement no more than 12 months old, which verifies that the original claim was received within 12 months of the service date.

Additional documentation that may be attached to claims for processing for possible payment is:

- A screen print from KYHealth-Net verifying eligibility issuance date and eligibility dates must be attached behind the claim;
- A screen print from KYHealth-Net verifying filing within 12 months from date of service, such as the appropriate section of the Remittance Advice or from the Claims Inquiry Summary Page (accessed via the Main Menu's Claims Inquiry selection);
- A copy of the Medicare Explanation of Medicare Benefits received 12 months after service date but less than six months after the Medicare adjudication date; and,
- A copy of the commercial insurance carrier's Explanation of Benefits received 12 months after service date but less than six months after the commercial insurance carrier's adjudication date.

### 5.2 Retroactive Eligibility (Back-Dated) Card

Aged claims for Members whose eligibility for Medicaid is determined retroactively may be considered for payment if filed within one year from the eligibility issuance date. Claim submission must be within 12 months of the issuance date. A copy of the KYHealth-Net card issuance screen must be attached behind the paper claim.

### 5.3 Unacceptable Documentation

Copies of previously submitted claim forms, providers' in-house records of claims submitted, or letters detailing filing dates are not acceptable documentation of timely billing. Attachments must prove the claim was received in a timely manner by HP Enterprise Services.



## 5.4 Third Party Coverage Information

### 5.4.1 Commercial Insurance Coverage (this does NOT include Medicare)

When a claim is received for a Member whose eligibility file indicates other health insurance is active and applicable for the dates of services, and no payment from other sources is entered on the Medicaid claim form, the claim is automatically denied unless documentation is attached.

### 5.4.2 Documentation That May Prevent A Claim from Being Denied for Other Coverage

The following forms of documentation prevent claims from being denied for other health insurance when attached to the claim.

1. Remittance statement from the insurance carrier that includes:

- Member name;
- Date(s) of service;
- Billed information that matches the billed information on the claim submitted to Medicaid; and,
- An indication of denial or that the billed amount was applied to the deductible.

**NOTE: Rejections from insurance carriers stating “additional information necessary to process claim” is not acceptable.**

2. Letter from the insurance carrier that includes:

- Member name;
- Date(s) of service(s);
- Termination or effective date of coverage (if applicable);
- Statement of benefits available (if applicable); and,
- The letter must have a signature of an insurance representative, or be on the insurance company's letterhead.

3. Letter from a provider that states they have contacted the insurance company via telephone. The letter must include the following information:

- Member name;
- Date(s) of service;
- Name of insurance carrier;
- Name of and phone number of insurance representative spoken to or a notation indicating a voice automated response system was reached;
- Termination or effective date of coverage; and,
- Statement of benefits available (if applicable).

4. A copy of a prior remittance statement from an insurance company may be considered an acceptable form of documentation if it is:
  - For the same Member;
  - For the same or related service being billed on the claim; and,
  - The date of service specified on the remittance advice is no more than six months prior to the claim's date of service.

**NOTE: If the remittance statement does not provide a date of service, the denial may only be acceptable by HP Enterprise Services if the date of the remittance statement is no more than six months from the claim's date of service.**

5. Letter from an employer that includes:
  - Member name;
  - Date of insurance or employee termination or effective date (if applicable); and,
  - Employer letterhead or signature of company representative.

#### **5.4.3 When there is no response within 120 days from the insurance carrier**

When the other health insurance has not responded to a provider's billing within 120 days from the date of filing a claim, a provider may complete a TPL Lead Form. Write "no response in 120 days" on either the TPL Lead Form or the claim form, attach it to the claim and submit it to HP Enterprise Services. HP Enterprise Services overrides the other health insurance edits and forwards a copy of the TPL Lead form to the TPL Unit. A member of the TPL staff contacts the insurance carrier to see why they have not paid their portion of liability.

#### **5.4.4 For Accident And Work Related Claims**

For claims related to an accident or work related incident, the provider should pursue information relating to the event. If an employer, individual, or an insurance carrier is a liable party but the liability has not been determined, claims may be submitted to HP Enterprise Services with an attached letter containing any relevant information, such as, names of attorneys, other involved parties and/or the Member's employer to:

HP Enterprise Services  
ATTN: TPL Unit  
P.O. Box 2107  
Frankfort, KY 40602-2107

#### 5.4.4.1 TPL Lead Form

HP Enterprise Services

*HP Enterprise Services  
Attention: TPL Unit  
P.O. Box 2107  
Frankfort, KY 40602-2107*

#### Third Party Liability Lead Form

Provider Name: \_\_\_\_\_ Provider #: \_\_\_\_\_  
Member Name: \_\_\_\_\_ Member #: \_\_\_\_\_  
Address: \_\_\_\_\_ Date of Birth: \_\_\_\_\_  
From Date of Service: \_\_\_\_\_ To Date of Service: \_\_\_\_\_  
Date of Admission: \_\_\_\_\_ Date of Discharge: \_\_\_\_\_  
Insurance Carrier Name: \_\_\_\_\_  
Address: \_\_\_\_\_  
Policy Number: \_\_\_\_\_ Start Date: \_\_\_\_\_ End Date: \_\_\_\_\_  
Date Claim Was Filed with Insurance Carrier: \_\_\_\_\_

Please check the one that applies:

\_\_\_\_\_ No Response in Over 120 Days  
\_\_\_\_\_ Policy Termination Date: \_\_\_\_\_  
\_\_\_\_\_ Other: Please explain in the space provided below

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Contact Name: \_\_\_\_\_ Contact Telephone #: \_\_\_\_\_  
Signature: \_\_\_\_\_ Date: \_\_\_\_\_

DMS Approved: January 10, 2011

## 5.5 Provider Inquiry Form

Provider Inquiry Forms may be used for any unique questions concerning claim status; paid or denied claims; and billing concerns. The mailing address for the Provider Inquiry Form is:

HP Enterprise Services  
Provider Services  
P.O. Box 2100  
Frankfort, KY 40602-2100

Please keep the following points in mind when using this form:

- Send the completed form to HP Enterprise Services. A copy is returned with a response;
- When resubmitting a corrected claim, do not attach a Provider Inquiry Form;
- A toll free HP Enterprise Services number **1-800-807-1232** is available in lieu of using this form; and,
- To check claim status, call the HP Enterprise Services Voice Response on **1-800-807-1301**.

**Provider Inquiry Form****HP Enterprise Services Corporation****Post Office Box 2100****Frankfort, KY 40602-2100**

Did you know that electronic claim submission can reduce your processing time significantly? You can also check claim status, verify eligibility, download remittance advices, and many other functions. Go to [www.kymmms.com](http://www.kymmms.com) or contact Billing Inquiry at 1-800-807-1232 for more information. You may also send an inquiry via e-mail at [ky\\_provider\\_inquiry@hp.com](mailto:ky_provider_inquiry@hp.com)

1. Provider Number	3. Member Name (first, last)	
2. Provider Name and Address	4. Medical Assistance Number	
	5. Billed Amount	6. Claim Service Date
7. Email	8. ICN (if applicable)	
9. Provider's Message		

10.

Signature

Date

**HP Enterprise Services Response: OFFICE USE ONLY**

\_\_\_\_\_ This claim has been resubmitted for possible payment.

\_\_\_\_\_ This claim paid on \_\_\_\_\_ in the amount of \_\_\_\_\_

\_\_\_\_\_ This claim was denied on \_\_\_\_\_ with EOB code \_\_\_\_\_

\_\_\_\_\_ Aged claim. Please see attached documentation concerning services submitted past the 12 month filing limit.

Other: \_\_\_\_\_

Signature

Date

**HIPAA Privacy Notification:** This message and accompanying documents are covered by the Communications Privacy Act, 18 U.S.C. 2510-2521, and contain information intended for the specified individual(s) only. This information is confidential. If you are not the intended recipient or an agent responsible for delivering it to the intended recipient, you are hereby notified that you have received this document in error and that any review, dissemination, copying, or the taking of any action based on the contents of this information is strictly prohibited. If you have received this communication in error, please notify us immediately and delete the original message.

## **5.6 Prior Authorization Information**

- The prior authorization process does NOT verify anything except medical necessity. It does not verify eligibility nor age.
- The prior authorization letter does not guarantee payment. It only indicates that the service is approved based on medical necessity.
- If the individual does not become eligible for Kentucky Medicaid, loses Kentucky Medicaid eligibility, or ages out of the program eligibility, services will not be reimbursed despite having been deemed medically necessary.
- Prior Authorization should be requested prior to the provision of services except in cases of:
  - Retro-active Member eligibility
  - Retro-active provider number
- Providers should always completely review the Prior Authorization Letter prior to providing services or billing.

Access the KYHealth Net website to obtain blank Prior Authorization forms.

<http://www.kymmis.com/kymmis/Provider%20Relations/PriorAuthorizationForms.aspx>

Access to Electronic Prior Authorization request (EPA).

<https://home.kymmis.com>

## **5.7 Adjustments And Claim Credit Requests**

An adjustment is a change to be made to a "PAID" claim. The mailing address for the Adjustment Request form is:

HP Enterprise Services  
P.O. Box 2108  
Frankfort, KY 40602-2108  
Attn: Financial Services

Please keep the following points in mind when filing an adjustment request:

- Attach a copy of the corrected claim and the paid remittance advice page to the adjustment form. For a Medicaid/Medicare crossover, attach an EOMB (Explanation of Medicare Benefits) to the claim;
- Do not send refunds on claims for which an adjustment has been filed;
- Be specific. Explain exactly what is to be changed on the claim;
- Claims showing paid zero dollar amounts are considered paid claims by Medicaid. If the paid amount of zero is incorrect, the claim requires an adjustment; and,
- An adjustment is a change to a paid claim; a claim credit simply voids the claim entirely.

HP Enterprise Services

**ADJUSTMENT AND CLAIM CREDIT REQUEST FORM**

**MAIL TO:** HP Enterprise Services  
P.O. BOX 2108  
FRANKFORT, KY 40602-2108  
1-800-807-1232  
ATTN: FINANCIAL SERVICES

**NOTE:** A CLAIM CREDIT VOIDS THE CLAIM ICN FROM THE SYSTEM -- A "NEW DAY" CLAIM MAY BE SUBMITTED, IF NECESSARY. THIS FORM WILL BE RETURNED TO YOU IF THE REQUIRED INFORMATION AND DOCUMENTATION FOR PROCESSING ARE NOT PRESENT. PLEASE ATTACH A CORRECTED CLAIM AND REMITTANCE ADVICE TO ADJUST A CLAIM.

<b>CHECK APPROPRIATE BOX:</b> CLAIM ADJUSTMENT <input type="checkbox"/> CLAIM CREDIT <input type="checkbox"/>		1. Original Internal Control Number (ICN)	
2. Member Name		3. Member Medicaid Number	
4. Provider Name and Address	5. Provider	6. From Date of Service	7. To Date of Service
	8. Original Billed Amount	9. Original Paid Amount	10. Remittance Advice Date

11. Please specify **WHAT** is to be adjusted on the claim. You must explain in detail in order for an adjustment specialist to understand what needs to be accomplished by adjusting the claim.

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12. Please specify the **REASON** for the adjustment or claim credit request.

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13. Signature \_\_\_\_\_ 14. Date \_\_\_\_\_

DMS Approved: January 10, 2011



## **5.8 Cash Refund Documentation Form**

The Cash Refund Documentation Form is used when refunding money to Medicaid. The mailing address for the Cash Refund Form is:

HP Enterprise Services  
P.O. Box 2108  
Frankfort, KY 40602-2108  
Attn: Financial Services

Please keep the following points in mind when refunding:

- Attach the Cash Refund Documentation Form to a check made payable to the KY State Treasurer.
- Attach applicable documentation, such as a copy of the remittance advice showing the claim for which a refund is being issued.
- If refunding all claims on an RA, the check amount must match the total payment amount on the RA. If refunding multiple RAs, a separate check must be issued for each RA.

HP Enterprise Services

Mail To: HP Enterprise Services  
P.O. Box 2108  
Frankfort, KY 40602-2108  
ATTN: Financial Services

## CASH REFUND DOCUMENTATION

<b>1. Check Number</b>						<b>2. Check Amount</b>							
<b>3. Provider Name/ID /Address</b>													
						<b>4. Member Name</b>							
						<b>5. Member Number</b>							
<b>6. From Date of Service</b>				<b>7. To Date of Service</b>				<b>8. RA Date</b>					
<b>9. Internal Control Number (If several ICNs, attach RAs)</b>													
<div style="text-align: center;">                                 </div>													

## Research for Refund: (Check appropriate blank)

- a.** Payment from other source - Check the category and list name (*attach copy of EOB*)  
       \_\_\_\_\_ Health Insurance  
       \_\_\_\_\_ Auto Insurance  
       \_\_\_\_\_ Medicare Paid  
       \_\_\_\_\_ Other
- b.** Billed in error
- c.** Duplicate payment (*attach a copy of both RAs*)  
*If RAs are paid to two different providers, specify to which provider ID the check is to be applied.*
- |  |  |  |  |  |  |  |  |  |  |
|--|--|--|--|--|--|--|--|--|--|
|  |  |  |  |  |  |  |  |  |  |
|--|--|--|--|--|--|--|--|--|--|
- d.** Processing error OR overpayment (explain why)
- 
- 
- e.** Paid to wrong provider
- f.** Money has been requested - date of the letter \_\_\_\_\_ | \_\_\_\_\_  
 (attach a copy of letter requesting money)
- g.** Other \_\_\_\_\_
- 
- 

Contact Name	Phone
--------------	-------

DMS Approved: January 10, 2011

## **5.9 Return To Provider Letter**

Claims and attached documentation received by HP Enterprise Services are screened for required information (listed below). If the required information is not complete, the claim is returned to the provider with a "Return to Provider Letter" attached explaining why the claim is being returned.

A claim is returned before processing if the following information is missing:

- Provider ID;
- Member Identification number;
- Member first and last names; and,
- EOMB for Medicare/Medicaid crossover claims.

Other reasons for return may include:

- Illegible claim date of service or other pertinent data;
- Claim lines completed exceed the limit; and,
- Unable to image.

HP

## RETURN TO PROVIDER LETTER

Date: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

Dear Provider,

The attached claim is being returned for the following reason(s). These items require correction before the claim can be processed.

- 01) ☐ PROVIDER NUMBER – A valid 8-digit provider number must be on the claim form in the appropriate field.  
☐ Missing ☐ Not a valid provider number
- 02) ☐ PROVIDER SIGNATURE – All claims require an original signature in the provider signature block. The Provider signature cannot be stamped or typed on the claim.  
☐ Missing  
☐ Typed signature not valid  
☐ Stamped signature not valid.
- 03) ☐ Detail lines exceed the limit for claim type.
- 04) ☐ UNABLE TO IMAGE OR KEY – Claim form/EOMB must be legible. Highlighted forms cannot be accepted. Please resubmit on a new form.  
☐ Print too light ☐ Print too dark ☐ Highlighted data fields ☐ Not legible ☐ Dark copy
- 05) ☐ Medicaid **does not** make payment when Medicare has paid the amount in full.
- 06) ☐ The Recipient's Medicaid (MAID) number is missing
- 07) ☐ Medicare EOMB does not match the claim  
☐ Dates of Service ☐ Recipient Number ☐ Charges ☐ Balance due in Block 30
- 08) ☐ Other Reason- \_\_\_\_\_

\_\_\_\_\_ **Claims are being returned to you for correction for the reasons noted above.**

<b>Helpful Hints When Billing for Services Provided to a Medicaid Recipient</b>
---

- The Recipient's Medicaid number on the HCFA must be entered Field 9A
- The Recipient's Medicaid number on the UB92 must be entered in Block 60
- Medicare numbers **are not** valid Medicaid numbers
- Please refer to your billing manual if you have any concerns about billing the Medicaid program correctly.

Please make the necessary corrections and resubmit for processing. If you have any questions, please feel free to contact our Provider Relations Group, open Monday through Friday, 8:00 a.m. until 6:00 p.m. eastern standard/daylight savings time, at 1-800-807-1232.

**If you are interested in billing Medicaid electronically please contact EDS at 1-800-205-4696 7:30 AM to 6PM Monday through Friday except holidays.**

Initials of clerk \_\_\_\_\_

Provider Name \_\_\_\_\_

Provider Number \_\_\_\_\_

Reason Code \_\_\_\_\_

## 5.10 Provider Representative List

### 5.10.1 Phone Numbers and Assigned Counties

<b>JACKIE RICHIE</b> <b>502-209-3100</b> <b>Extension 2021273</b> <b>jackie.richie@hp.com</b>			<b>VICKY HICKS</b> <b>502-209-3100</b> <b>Extension 2021263</b> <b>vicky.hicks@hp.com</b>			<b>PENNY GERMINARO</b> <b>502-209-3100</b> <b>Extension 2021281</b> <b>penny.germinaro@hp.com</b>
Assigned Counties			Assigned Counties			Assigned Counties
ADAIR	HARLAN	MCLEAN	ANDERSON	GRAYSON	MERCER	ALLEN
BALLARD	HENDERSON	MCCREARY	BATH	GREENUP	MONTGOMERY	BARREN
BELL	HICKMAN	METCALFE	BOURBON	HANCOCK	MORGAN	BOONE
BOYLE	HOPKINS	MONROE	BOYD	HARDIN	NELSON	CAMPBELL
BREATHITT	JACKSON	MUHLENBERG	BRACKEN	HARRISON	NICHOLAS	CARROLL
BULLITT	JEFFERSON	OLDHAM	BRECKINRIDGE	JESSAMINE	OHIO	EDMONSON
CALDWELL	KNOTT	OWSLEY	BUTLER	JOHNSON	POWELL	GALLATIN
CALLOWAY	KNOX	PERRY	CARTER	LAWRENCE	ROBERTSON	GRANT
CARLISLE	LARUE	PIKE	CLARK	LEE	ROWAN	HART
CASEY	LAUREL	PULASKI	DAVISS	LEWIS	SHELBY	HENRY
CHRISTIAN	LESLIE	ROCKCASTLE	ELLIOTT	MADISON	SPENCER	KENTON
CLAY	LETCHER	RUSSELL	ESTILL	MAGOFFIN	WASHINGTON	OWEN
CLINTON	LINCOLN	TAYLOR	FAYETTE	MARTIN	WOLFE	PENDLETON
CRITTENDEN	LIVINGSTON	TODD	FLEMING	MASON	WOODFORD	SCOTT
CUMBERLAND	LOGAN	WAYNE	FRANKLIN	MEADE		SIMPSON
FLOYD	LYON	WHITLEY	GARRARD	MENIFEE		TRIMBLE
FULTON	MARION	TRIGG				WARREN
GRAVES	MARSHALL	UNION				
GREEN	MCCRACKEN	WEBSTER				

- **NOTE – Out-of-state providers contact the Representative who has the county closest bordering their state, unless noted above.**
- **Provider Relations 1-800-807-1232**

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## **6 Completion Of UB-04 Billing Form With NPI**

### **6.1 UB-04 With NPI Billing Instructions**

Following are form locator numbers and form locator instructions for billing PRTF services on the UB-04 billing form. Only instructions for form locators required for HP Enterprise Services processing or for KY Medicaid Program information are included. Instructions for form locators not used by HP Enterprise Services or the KY Medicaid Program can be found in the UB-04 Training Manual. The UB-04 Training Manual may be obtained from the Kentucky Hospital Association. You may also obtain the UB-04 billing forms from the address and phone number listed below:

Kentucky Hospital Association  
P.O. Box 24163  
Louisville, KY 40224  
Telephone: 1-502-426-6220

Claims for covered psychiatric residential treatment facility services provided to eligible KY Medicaid Members must be submitted monthly to the KY Medicaid program. A full calendar month's billing is required unless the resident is newly admitted to the facility during the month, is discharged, expires, or authorization for benefit provisions is withdrawn by Mental Health Management of America (MHMA) on the basis that further stay is not medically necessary. Providers should not split-bill for a month's service (submit bills more frequently than a full calendar month - 1st through 15th; 16th through 31st).

A separate UB-04 form must be used for each resident. An original UB-04 billing form must be submitted to HP Enterprise Services for claims processing. The provider should retain a copy of the billing form.

The original UB-04 billing form must be sent to:

HP Enterprise Services  
P.O. Box 2106  
Frankfort, KY 40602-2106

09/04/2012

1 Provider Name		2		3a PAT CNTL # b. MED REC #		Patient Control Number		4 TYPE OF BILL 0811	
Street Address									
City or Town				ST ZIP		5 FED TAX NO.		6 STATEMENT COVERS PERIOD FROM THROUGH	
AC+Phone Number						010107		013107	
8 PATIENT NAME				a		9 PATIENT ADDRESS			
b				b		c d e			
10 BIRTHDATE		11 SEX		12 DATE		13 HR		14 TYPE	
15 SRC		16 DHR		17 STAT		18		19	
20		21		22		23		24	
25		26		27		28		29	
30		31		32		33		34	
35		36		37		38		39	
40		41		42		43		44	
45		46		47		48		49	
50		51		52		53		54	
55		56		57		58		59	
60		61		62		63		64	
65		66		67		68		69	
70		71		72		73		74	
75		76		77		78		79	
80		81		82		83		84	
85		86		87		88		89	
90		91		92		93		94	
95		96		97		98		99	

## 6.3 Completion of UB-04 Claim Form With NPI and Taxonomy

### 6.3.1 Detailed Instructions

Included is a representative sample of codes and/or services that may be covered by KY Medicaid.

FORM LOCATOR NUMBER	FORM LOCATOR NAME AND DESCRIPTION	
1	<b>Provider Name, Address and Telephone</b>	
	Enter the complete name, address, and telephone number (including area code) of the facility.	
3	<b>Patient Control Number</b>	
	Enter the patient control number. The first 14 digits (alpha/numeric) will appear on the remittance advice as the invoice number.	
4	<b>Type of Bill</b>	
	Enter the appropriate code to indicate the type of bill.	
	1st Digit	Enter zero
	2nd Digit (Type of Facility)	8 = Psychiatric Residential Treatment Facility Service
	3rd Digit (Bill Classification)	1 = Inpatient
	4th Digit (Frequency)	1 = Admit through discharge 2 = Interim, first claim 3 = Interim, continuing claim 4 = Interim, final claim
6	<b>Statement Covers Period</b>	
	<b>FROM:</b> Enter the beginning date of the billing period covered by this invoice in numeric format (MMDDYY).	
	<b>THROUGH:</b> Enter the last date of the billing period covered by this invoice in numeric format (MMDDYY).	
	Do not include days prior to when the Member's KY Medicaid eligibility period began.  The "FROM" date is the date of the admission if the Member was eligible for the KY Medicaid benefits upon admission. If the Member was not eligible on the date of admission, the "FROM" date is the effective date of eligibility.	



	The "THROUGH" date is the last covered day of the hospital stay.	
<b>10</b>	<b>Date of Birth</b>	
	Enter the member's date of birth.	
<b>12</b>	<b>Admission Date</b>	
	Enter the date on which the Member was admitted to the facility in numeric format (MMDDYY).	
<b>17</b>	<b>Patient Status Code</b>	
	Enter the appropriate two-digit patient status code indicating the disposition of the patient as of the "through" date in Form Locator 6.	
	<b>Status Codes Accepted by KY Medicaid</b>	
	01	Discharged to Home or Self Care (Routine Discharge)
	02	Discharged or Transferred to Acute Hospital
	03	Discharged or Transferred to Skilled Nursing Facility (SNF) or NF
	04	Discharged or Transferred to Intermediate Care Facility (ICF)
	05	Discharged or Transferred to Another Type of Institution
	06	Discharged or Transferred to Home Under Care of Organized Home Health Service Organization
	07	Left Against Medical Advice
	10	Discharged or Transferred to Mental Health Center or Mental Hospital
	20	Expired
	21	Discharge or Transfer to Court/Law Enforcement
	30	Still a Resident
<b>18-28</b>	<b>Condition Codes</b>	
	Peer Review Organization (PRO) Indicator	
	Enter the appropriate indicator, which describes the determination of the PRO/Utilization Review Committee.	

	<p>C1 = Approved as Billed</p> <p>C2 = Automatic Approval as Billed Based on Focus Review</p> <p>C3 = Partial Approval*</p>
	<p>The condition codes are also included in the UB-04 Training Manual. Information regarding the Peer Review Organization is located in the Reference Index.</p>
<b>31-34</b>	<b>Occurrence Codes and Dates</b>
	<p>Enter the appropriate code(s) and date(s) defining a significant event relating to this bill. Reference the UB-04 Training Manual for additional codes.</p>
<b>35-36</b>	<b>Occurrence Span Code and Dates</b>
	<p>Enter occurrence span code "MO" and the first and last days approved by the PRO/UR when condition code C3 (partial approval) has been entered in Form Locators 18-28.</p>
<b>39-41</b>	<b>Value Codes</b>
	<p>80 = Covered Days</p> <p>Enter the total number of covered days from Form Locator 6. Data entered in Form Locator 39 must agree with accommodation units in Form Locator 46. Covered days are not required for Medicare crossover claims for coinsurance days or life reserve days.</p> <p>82 = Coinsurance Days</p> <p>Enter the number of coinsurance days billed to the KY Medicaid Program during this billing period. Attach EOMB.</p> <p>83 = Life Time Reserve Days</p> <p>Enter the Lifetime Reserve days the patient has elected to use for this billing period. Attach EOMB.</p> <p>A1 = Deductible Payer A</p> <p>Enter the amount as shown on the EOMB to be applied to the Member's deductible amount due. Attach EOMB.</p> <p>A2 = Coinsurance Payer A</p> <p>Enter the amount as shown on the EOMB to be applied toward Member's coinsurance amount due. Attach EOMB</p> <p>B1 = Deductible Payer B</p> <p>Enter the amount as shown on the EOMB to be applied to the Member's deductible amount due. Attach EOMB.</p>

	<p>B2 = Coinsurance Payer B</p> <p>Enter the amount as shown on the EOMB to be applied toward Member's coinsurance amount due. Attach EOMB</p>
<b>42</b>	<b>Revenue Codes</b>
	<p>Enter the three digit revenue code identifying specific accommodation and ancillary services.</p> <p><b>NOTE: Total charge Revenue code 0001 must be the final entry in column 42, line 23. Total charge amount must be shown in column 47, line 23.</b></p>
<b>43</b>	<b>Description</b>
	Enter the standard abbreviation assigned to each revenue code.
<b>44</b>	<b>HCPCS / Rates</b>
	Enter the facility's usual and customary charge for accommodation revenue code(s) in dollar and cents format (00.00).
<b>45</b>	<b>Creation Date</b>
	Enter the invoice date or invoice creation date.
<b>46</b>	<b>Unit</b>
	Enter the quantitative measure of services provided per revenue code.
<b>47</b>	<b>Total Charges</b>
	<p>Enter the total charges relating to each revenue code for the billing period. The detailed revenue code amounts must equal the entry "total charges."</p> <p>Claim total must be shown in field 47, line 23.</p>
<b>48</b>	<b>Non-Covered Charges</b>
	Enter the charges from Form Locator 47 that are non-payable by KY Medicaid.
<b>50</b>	<b>Payer Identification</b>
	<p>Enter the names of payer organizations from which the provider receives payment. For Medicaid, use KY Medicaid. All other liable payers, including Medicare, must be billed first.*</p> <p>* KY Medicaid is payer of last resort.</p>
<b>54</b>	<b>Prior Payments</b>
	Enter the amount the facility has received toward payment of the claim. Third party payment should be entered in this area. Do not enter Medicare payment amounts in this area. Do not enter continuing income

	amounts in this area.
<b>56</b>	<b>NPI</b>
	Enter the PAY TO NPI number.
<b>57</b>	<b>Taxonomy</b>
	Enter the PAY TO Taxonomy number.
<b>57B</b>	<b>Other</b>
	Enter the facilities zip code.
<b>58</b>	<b>Insured's Name</b>
	Enter the Member's name in Form Locators 58 A, B, and C that relates to the payer in Form Locators 50 A, B, and C. Enter the Member's name exactly as it appears on the Member Identification card in last name, first name, and middle initial format.
<b>60</b>	<b>Identification Number</b>
	Enter the Member Identification number in Form Locators 60 A, B, and C that relates to the Member's name in Form Locators 58 A, B, and C. Enter the 10 digit Member Identification number exactly as it appears on the Member Identification card.
<b>63</b>	<b>Treatment Authorization Number</b>
	Enter the treatment authorization number assigned by the PRO/UR designating that the treatment covered by the bill is authorized by the PRO/UR.
<b>67</b>	<b>Principal Diagnosis Code</b>
	Enter the ICD-9-CM Vol. 1 and 2 code describing the principal diagnosis.
<b>67A-Q</b>	<b>Other Diagnosis Code</b>
	Enter the ICD-9-CM Vol. 1 and 2 codes that co-exist at the time the service is provided.
<b>69</b>	<b>Admitting Diagnosis</b>
	Enter the ICD-9-CM diagnosis code describing the admitting diagnosis.
<b>76</b>	<b>Attending Physician ID</b>
	Enter the Attending Physician NPI number.

**NOTE: KY Medicaid advises providers to use this method when a single NPI corresponds to a single KY Medicaid provider ID.**

IR-04 CMS-1460

APPROVED OMB NO.

THE CERTIFICATIONS ON THE REVERSE APPLY TO THIS BILL AND ARE MADE A PART HEREOF.

NUBC<sup>®</sup> National Union  
Billing Committee  
UC921325

## 6.5 Completion of UB-04 Claim Form With NPI Alone

### 6.5.1 Detailed Instructions

Included is a representative sample of codes and/or services that may be covered by KY Medicaid.

**NOTE:** Those KY Medicaid providers who have a one to one match between the NPI number and the KY Medicaid provider number do not require the use of the Taxonomy when billing. If the NPI number corresponds to more than one KY Medicaid provider number, Taxonomy will be a requirement on the claim.

FORM LOCATOR NUMBER	FORM LOCATOR NAME AND DESCRIPTION	
1	<b>Provider Name, Address and Telephone</b>	
	Enter the complete name, address, and telephone number (including area code) of the facility.	
3	<b>Patient Control Number</b>	
	Enter the patient control number. The first 14 digits (alpha/numeric) will appear on the remittance advice as the invoice number.	
4	<b>Type of Bill</b>	
	Enter the appropriate code to indicate the type of bill.	
	1st Digit	Enter zero
	2nd Digit (Type of Facility)	8 = Psychiatric Residential Treatment Facility Service
	3rd Digit (Bill Classification)	1 = Inpatient
	4th Digit (Frequency)	1 = Admit through discharge 2 = Interim, first claim 3 = Interim, continuing claim 4 = Interim, final claim
6	<b>Statement Covers Period</b>	
	<b>FROM:</b> Enter the beginning date of the billing period covered by this invoice in numeric format (MMDDYY).	
	<b>THROUGH:</b> Enter the last date of the billing period covered by this invoice in numeric format (MMDDYY).	
	Do not include days prior to when the Member's KY Medicaid eligibility period began.  The "FROM" date is the date of the admission if the Member was eligible for the KY Medicaid benefits upon admission. If the Member was not	

	<p>eligible on the date of admission, the “FROM” date is the effective date of eligibility.</p> <p>The “THROUGH” date is the last covered day of the hospital stay.</p>
<b>10</b>	<b>Date of Birth</b>
	Enter the member’s date of birth.
<b>12</b>	<b>Admission Date</b>
	Enter the date on which the Member was admitted to the facility in numeric format (MMDDYY).
<b>17</b>	<b>Patient Status Code</b>
	Enter the appropriate two-digit patient status code indicating the disposition of the patient as of the “through” date in Form Locator 6.
	<b>Status Codes Accepted by KY Medicaid</b>
	01 Discharged to Home or Self Care (Routine Discharge)
	02 Discharged or Transferred to Acute Hospital
	03 Discharged or Transferred to Skilled Nursing Facility (SNF) or NF
	04 Discharged or Transferred to Intermediate Care Facility (ICF)
	05 Discharged or Transferred to Another Type of Institution
	06 Discharged or Transferred to Home Under Care of Organized Home Health Service Organization
	07 Left Against Medical Advice
	10 Discharged or Transferred to Mental Health Center or Mental Hospital
	20 Expired
	21 Discharge or Transfer to Court/Law Enforcement
	30 Still a Resident
<b>18-28</b>	<b>Condition Codes</b>
	Peer Review Organization (PRO) Indicator

	Enter the appropriate indicator, which describes the determination of the PRO/Utilization Review Committee.
	C1 = Approved as Billed C2 = Automatic Approval as Billed Based on Focus Review C3 = Partial Approval*
	The condition codes are also included in the UB-04 Training Manual. Information regarding the Peer Review Organization is located in the Reference Index.
<b>31-34</b>	<b>Occurrence Codes and Dates</b>
	Enter the appropriate code(s) and date(s) defining a significant event relating to this bill. Reference the UB-04 Training Manual for additional codes.
<b>35-36</b>	<b>Occurrence Span Code and Dates</b>
	Enter occurrence span code "MO" and the first and last days approved by the PRO/UR when condition code C3 (partial approval) has been entered in Form Locators 18-28.
<b>39-41</b>	<b>Value Codes</b>
	<p>80 = Covered Days</p> <p>Enter the total number of covered days from Form Locator 6. Data entered in Form Locator 39 must agree with accommodation units in Form Locator 46. Covered days are not required for Medicare crossover claims for coinsurance days or life reserve days.</p> <p>82 = Coinsurance Days</p> <p>Enter the number of coinsurance days billed to the KY Medicaid Program during this billing period. Attach EOMB.</p> <p>83 = Life Time Reserve Days</p> <p>Enter the Lifetime Reserve days the patient has elected to use for this billing period. Attach EOMB.</p> <p>A1 = Deductible Payer A</p> <p>Enter the amount as shown on the EOMB to be applied to the Member's deductible amount due. Attach EOMB.</p> <p>A2 = Coinsurance Payer A</p> <p>Enter the amount as shown on the EOMB to be applied toward Member's coinsurance amount due. Attach EOMB</p> <p>B1 = Deductible Payer B</p>



	<p>Enter the amount as shown on the EOMB to be applied to the Member's deductible amount due. Attach EOMB.</p> <p>B2 = Coinsurance Payer B</p> <p>Enter the amount as shown on the EOMB to be applied toward Member's coinsurance amount due. Attach EOMB</p>
<b>42</b>	<b>Revenue Codes</b>
	<p>Enter the three digit revenue code identifying specific accommodation and ancillary services.</p> <p><b>NOTE: Total charge Revenue code 0001 must be the final entry in column 42, line 23. Total charge amount must be shown in column 47, line 23.</b></p>
<b>43</b>	<b>Description</b>
	Enter the standard abbreviation assigned to each revenue code.
<b>44</b>	<b>HCPCS / Rates</b>
	Enter the facility's usual and customary charge for accommodation revenue code(s) in dollar and cents format (00.00).
<b>45</b>	<b>Creation Date</b>
	Enter the invoice date or invoice creation date.
<b>46</b>	<b>Unit</b>
	Enter the quantitative measure of services provided per revenue code.
<b>47</b>	<b>Total Charges</b>
	<p>Enter the total charges relating to each revenue code for the billing period. The detailed revenue code amounts must equal the entry "total charges."</p> <p>Claim total must be shown in field 47, line 23.</p>
<b>48</b>	<b>Non-Covered Charges</b>
	Enter the charges from Form Locator 47 that are non-payable by KY Medicaid.
<b>50</b>	<b>Payer Identification</b>
	<p>Enter the names of payer organizations from which the provider receives payment. For Medicaid, use KY Medicaid. All other liable payers, including Medicare, must be billed first.*</p> <p>* KY Medicaid is payer of last resort.</p>
<b>54</b>	<b>Prior Payments</b>

	Enter the amount the facility has received toward payment of the claim. Third party payment should be entered in this area. Do not enter Medicare payment amounts in this area. Do not enter continuing income amounts in this area.
<b>56</b>	<b>NPI</b>
	Enter the PAY TO NPI number.  <b>NOTE: Those KY Medicaid providers who have a one to one match between the NPI number and the KY Medicaid provider number do not require the use of the Taxonomy when billing. If the NPI number corresponds to more than one KY Medicaid provider number, Taxonomy will be a requirement on the claim.</b>
<b>58</b>	<b>Insured's Name</b>
	Enter the Member's name in Form Locators 58 A, B, and C that relates to the payer in Form Locators 50 A, B, and C. Enter the Member's name exactly as it appears on the Member Identification card in last name, first name, and middle initial format.
<b>60</b>	<b>Identification Number</b>
	Enter the Member Identification number in Form Locators 60 A, B, and C that relates to the Member's name in Form Locators 58 A, B, and C. Enter the 10 digit Member Identification number exactly as it appears on the Member Identification card.
<b>63</b>	<b>Treatment Authorization Number</b>
	Enter the treatment authorization number assigned by the PRO/UR designating that the treatment covered by the bill is authorized by the PRO/UR.
<b>67</b>	<b>Principal Diagnosis Code</b>
	Enter the ICD-9-CM Vol. 1 and 2 code describing the principal diagnosis.
<b>67A-Q</b>	<b>Other Diagnosis Code</b>
	Enter the ICD-9-CM Vol. 1 and 2 codes that co-exist at the time the service is provided.
<b>69</b>	<b>Admitting Diagnosis</b>
	Enter the ICD-9-CM diagnosis code describing the admitting diagnosis.
<b>76</b>	<b>Attending Physician ID</b>
	Enter the Attending Physician NPI number.

---

## **7 MAP 24 Memorandum**

### **7.1 To Local Community Based Services**

Use the MAP-24 to report the discharge or death of any Title XIX resident to the local Department for Community Based Services office. This flow of information is essential to timely payment to the facility and efficient records for the Community Based Services office. Complete all entries as appropriate and mail to the local Department for Community Based Services office within 10 days of discharge or death.



CABINET FOR HEALTH SERVICES  
COMMONWEALTH OF KENTUCKY  
FRANKFORT, 40621-0001

DEPARTMENT FOR MEDICAID SERVICES  
"An Equal Opportunity Employer M/F/D"

\_\_\_\_\_  
(Date)

**MEMORANDUM**

TO: Local Office  
Department for Community Based Services  
Cabinet for Families & Children

FROM: \_\_\_\_\_ Provider #: \_\_\_\_\_  
(Facility/Waiver Agency)

SUBJECT: \_\_\_\_\_  
(Recipient Name) (Social Security/Medicaid Number)  
\_\_\_\_\_  
(Previous Address)  
\_\_\_\_\_  
(Responsible Relative's Name & Address)

This is to notify you that the above-referenced recipient

☐ was admitted to this facility/waiver agency \_\_\_\_\_  
(Date)  
is in Title \_\_\_\_\_ Payment Status, and was placed in a  
(XVIII or XIX)

☐ NF bed ☐ ICF/MR/DD bed ☐ MH bed ☐ EPSDT Bed

☐ Home & Community Based Waiver Service ☐ SCL Waiver Service and/or

☐ was discharged from this facility/waiver agency on \_\_\_\_\_  
(Date)  
and went to \_\_\_\_\_  
(Home Address/Name & Address of New Facility/Waiver Agency)  
and/or expired on \_\_\_\_\_  
(Date)

☐ was re-instated to Home & Community Based or SCL waiver services within 60 days of the  
NF admission. \_\_\_\_\_  
(Date Re-Instated)

*For Home & Community Based waiver Clients only* – last date service was provided \_\_\_\_\_  
(Date)

\_\_\_\_\_  
(Signature)

MAP-24 (Rev. 02/2001)

---

## **7.2 Conditions of Reimbursement**

### **7.2.1 Mental Health Management Agency/Utilization Review Documentation**

The facility shall maintain information in each resident's medical record which documents each period of MHMA certification and which adequately identifies all services and treatments provided for the patient.

### **7.2.2 The Notice Of Availability Of Income For Long Term Care (MAP-552)**

#### **7.2.2.1 MAP-552/LO2 Process And Requirements**

The local office of the Department for Community Based Services (DCBS) shall initiate a Form MAP-552 after patient status has been established in a Psychiatric Residential Treatment Facility.

The Department for Community Based Services initiates action on the MAP-552 when they have received a Certification for Psychiatric Facility Placement form (LO2) from MHMA. Upon receipt of the LO2, the local DCBS staff conducts a financial investigation of the applicant and makes a determination as to the amount of income that is to be considered as "available income" to be applied toward the cost of care.

Receipt of the MAP-552 by the facility is notification that the facility can bill the KY Medicaid Program for services provided to a KY Medicaid resident. Since claims processed prior to entry into the system of continuing income data rejects, it is recommended that claims be submitted only after the MAP-552 is received by the Psychiatric Residential Treatment Facility.

When there is a change in the amount of the continuing income received by the resident (either an increase or a decrease), a MAP-552 shall be prepared by the DCBS eligibility worker. Income data entered on the MAP-552 remains in effect until a new MAP-552 is issued. A copy of a MAP-552 can be found on page 8-46.

#### **7.2.2.2 Income Disregard Period**

The resident income is disregarded through the month of admission when initially admitted to a facility; however, for residents in private pay status who become Title XIX eligible while in the facility, there is no income disregard period. The continuing income as indicated on the MAP-552 is to be collected by the facility from the resident or responsible party, for example family, guardian or conservator. A direct transfer to another psychiatric residential treatment facility shall not begin another period of income disregard. If the resident is out of provider payment status for thirty days or more, DMS allows a new income disregard period.

#### **7.2.2.3 Collection of Continuing Income For Partial Month of Service**

If a partial month of service is provided, the total amount of a resident's available income is not collected. The KY Medicaid Program automatically prorates the resident's available income and deducts from its payment that portion of the income available for collection for a partial month of service. The following formula is used:

- Days of Service X Resident's Available Income + Days in Month = Amount to be Collected from Resident or APPLICABLE INCOME for that Portion of the Month.
- Example: ten days X \$110 + 30 days in month. \$36.67

---

#### **7.2.2.4 Collection Of Continuing Income for Psychiatric Residential Treatment Facility Residents Admitted to a Mental Hospital**

If a Psychiatric Residential Treatment Facility resident is admitted to a mental hospital on leave of absence (LOA) days, continuing income is considered in payment to the Psychiatric Residential Treatment Facility. If the Psychiatric Residential Treatment Facility resident is admitted to a mental hospital and is not on leave of absence from the Psychiatric Residential Treatment Facility, continuing income is subtracted from the mental hospital payment.

Prior to billing KY Medicaid for a Psychiatric Residential Treatment Facility resident who is on leave of absence days to a mental hospital, the Psychiatric Residential Treatment Facility provider is required to complete form MAP-31 (Rev. 7/91) to list the number of leave of absence (LOA) days the resident is allowed for the Psychiatric Residential Treatment Facility during that admission to the mental hospital.

Instructions for completion of Psychiatric Residential Treatment Facility Notification Form MAP-31 may be found on page 9-50.

#### **7.2.2.5 Residents Committed To The Custody Of The Department for Community Based Services.**

The DCBS local office shall be notified of the placement of residents in a psychiatric residential treatment facility by the Department for Community Based Services. If a MAP-552 has not been received by the facility within 60 days the facility can, after an L02 has been issued by the MHMA Coordinator, contact the Division of Family Services within the Department for Community Based Services. Questions concerning placement of residents who are committed to the custody of the Department for Community Based Services shall be addressed to the Director's Office of the Division of Family Services at 1-502-564-5813.

### **7.3 Payment From Resident**

The KY Medicaid Program requires all Psychiatric Residential Treatment Facilities that participate in the Program to report ALL payments or deposits made toward a resident's account, regardless of the source of payment. In the event that the Psychiatric Residential Treatment Facility receives payment from an eligible KY Medicaid Program resident for a covered service, the KY Medicaid Program regulations preclude payment being made by the Program for that service unless documentation is received that the payment has been refunded. This policy does not apply to payments made by residents for non-covered services or continuing income amounts.

### **7.4 Equal Charge**

The charge made to the KY Medicaid Program shall be the same charge made for comparable services provided to any party or payor.

---

## **7.5 Duplicate or Inappropriate Payments**

Any duplicate or inappropriate payment by the KY Medicaid Program, whether due to erroneous billing or payment system faults, shall be refunded to the KY Medicaid Program. Refund checks shall be made payable to "KY State Treasurer" and sent immediately to:

HP Enterprise Services P.O. Box 2108  
Frankfort, KY 40602-2108  
ATTN: Financial Services Unit

Failure to refund a duplicate or inappropriate payment could be interpreted as fraud or abuse and prosecuted.

## **7.6 Deposits**

Deposits shall not be required or accepted of those persons eligible for KY Medicaid. Presentation of a current Member Identification Card and meeting patient status as determined by MHMA for Psychiatric Residential Treatment Facility Services constitute KY Medicaid eligibility for services. Any deposit obtained prior to KY Medicaid eligibility shall be returned to the resident or responsible party when eligibility is determined. Deposits must be refunded PRIOR TO BILLING THE KY MEDICAID PROGRAM.

## **7.7 Days**

- For KY Medicaid purposes, a day is considered in relation to the midnight census;
- KY Medicaid can pay the date of admission, but cannot pay the date of discharge (death). Charges incurred on the date of discharge (death) are KY Medicaid-allowable covered charges; and,
- Residents or responsible parties cannot be billed for the date of discharge (death).

## **7.8 Personal Items As A Component Of Routine Costs**

Resident's personal items (for example toothpaste, toothbrushes, deodorants, lotions, shampoo, paper tissues, mouthwashes etc.) are considered part of routine services. These items are provided without cost to the resident and are not billable to residents or responsible parties.

## **7.9 Leave Of Absence Policy**

The KY Medicaid Program can make payment to a Psychiatric Residential Treatment Facility during a Title XIX resident's absence for acute care hospitalization, mental hospital, psychiatric bed at an acute care hospital, and other leaves of absence provided certain criteria are met.

Facilities shall allow residents for whom KY Medicaid is paying to reserve a bed, to return to that bed, when they are ready for charge from the hospital or when returning from other leaves of absence, regardless of the day of the week, including holidays and weekends.

If the facility chooses not to reserve a bed for a resident for whom leave of absence days are available, the facility must advise the resident prior to his or her departure from the facility that a bed is not reserved for their use upon return from the hospital/home visit.

---

### **7.9.1 Criteria for Reimbursable Leaves of Absence**

- The resident's in Title XIX payment status and has been a resident of the facility at least overnight;
- The resident can be reasonably expected to return to the facility;
- Due to a demand at the facility for beds, there is likelihood that another resident would occupy the bed were it not reserved;
- Hospitalization must be in KY Medicaid participating hospitals. The admission must be approved by the KY Medicaid Program Peer Review Organization (PRO) or the KY Medicaid designated review agency, the MHMA; and,
- For leaves of absence other than for hospitalization, the resident's physician orders and plan of care provide for such leaves. Leaves of absence include visits with relatives and friends.

Vendor Payment For Leave of Absence Days Is Limited As Follows:

- A maximum of 14 days per admission for an acute care hospital stay;
- A maximum of 14 days per calendar year for admissions to a mental hospital or a psychiatric bed of an acute care hospital;
- A maximum of 21 days per six months periods during a calendar year (January through June and July through December) for other leaves of absence;
- A maximum of 30 consecutive days for hospital and other leaves of absence combined; and,
- Maximums are applied per provider.



MAP-552p COMMONWEALTH OF KENTUCKY  
(03/98) CABINET FOR HEALTH SERVICES  
DEPARTMENT FOR SOCIAL INSURANCE

NOTICE OF AVAILABILITY OF INCOME FOR LONG TERM CARE/WAIVER AGENCY/HOSPICE

MAID NUMBER: \_\_\_\_\_ ( ) CORRECTION

( ) INITIAL

PROGRAM: \_\_\_\_\_ ( ) CHANGE

CLIENT'S NAME: \_\_\_\_\_ DATE OF BIRTH: \_\_\_\_\_

PROVIDER NUMBER: \_\_\_\_\_

ADMISSION DATE: \_\_\_\_\_ DISCHARGE DATE: \_\_\_\_\_ DEATH DATE: \_\_\_\_\_

LEVEL OF CARE \_\_\_\_\_ LTC INELIGIBLE DATE: \_\_\_\_\_

FAMILY STATUS: \_\_\_\_\_ SPOUSE STATUS: \_\_\_\_\_

INCOME COMPUTATION:

UNEARNED INCOME SOURCE

AMOUNT

RSDI \$ \_\_\_\_\_

SSI \$ \_\_\_\_\_

RR \$ \_\_\_\_\_

VA \$ \_\_\_\_\_

STATE SUPPLEMENTATION \$ \_\_\_\_\_

OTHER \$ \_\_\_\_\_

SUB-TOTAL UNEARNED INC. \$ \_\_\_\_\_

EARNED INCOME

AMOUNT

WAGES \$ \_\_\_\_\_

EARNED INC. DEDUCTION \$ \_\_\_\_\_

SUB-TOTAL EARNED INC. \$ \_\_\_\_\_

TOTAL INCOME \$ \_\_\_\_\_

CASE STATUS

ACTIVE CASE: \_\_\_\_\_

IF ACTIVE, EFF. MA DATE: \_\_\_\_\_

IF DISC. EFF. MA DATE: \_\_\_\_\_

NOTIF. FORM: \_\_\_\_\_

NOTIF. FORM DATE: \_\_\_\_\_

DEDUCTIONS

AMOUNT

PERSONAL NEEDS ALLOWANCE \$ \_\_\_\_\_

INCREASED PNA \$ \_\_\_\_\_

SPOUSE/FAMILY MAINT. \$ \_\_\_\_\_

SMI \$ \_\_\_\_\_

HEALTH INS \$ \_\_\_\_\_

INCURRED MEDICAL EXPENSES \$ \_\_\_\_\_

EFF. DATE OF CORR: \_\_\_\_\_

ENDING DATE OF CORR: \_\_\_\_\_

PRIVATE PAY PATIENT

FROM: \_\_\_\_\_ THRU \_\_\_\_\_

---

## 8 Forms Requirements

### 8.1 Completion Of PRTF Notification (MAP-31)

The MAP-31 is used to report Leave of Absence (LOA) days to a psychiatric inpatient hospital by the Psychiatric Residential Treatment Facility Service in order to allow continuing income to be subtracted from the KY Medicaid payment. If the resident is not on leave of absence days, payment is subtracted from the psychiatric inpatient hospital payment.

This form is to be completed in full and copies forwarded to the appropriate state agencies. This flow of information is essential for timely payment to the facility and efficient records for the Department for Medicaid Services.

#### 8.1.1 Instructions For The Completion Of The (MAP-31)

<b>Psychiatric Residential Treatment Facility Service Center</b>	Enter the name of the facility where services were provided.
<b>Address</b>	Enter the mailing address of the facility.
<b>City, State, Zip Code</b>	Enter the mailing city, state and zip code of the facility
<b>Patient Name</b>	Enter the member's first and last name.
<b>Social Security Number</b>	Enter the member's social security number.
<b>Bed Reservation Days Available</b>	Enter the number of days a bed is being held available for the member.

<b>MARK APPROPRIATE BOX</b>	
<b>First Box</b>	Enter the beginning (date) of temporary absences and name of the (temporary facility).
<b>Second Box</b>	Enter (date) Member returned from name of (temporary facility).
<b>Third Box</b>	Enter (date) Member was officially discharged from this facility. Name of place where Member is now residing.

<b>Signature</b>	An authorized signature of provider representative.
<b>Title</b>	Enter the title of authorized signature.
<b>Date</b>	Enter the date of authorized signature.

**COMMONWEALTH OF KENTUCKY  
CABINET FOR HUMAN RESOURCES  
DEPARTMENT FOR MEDICAID SERVICES**

**PSYCHIATRIC RESIDENTIAL TREATMENT FACILITY SERVICE NOTIFICATION FORM**

TO: Department for Community Based Services

FROM:

\_\_\_\_\_  
(Psychiatric Residential Treatment Facility Service Center)

\_\_\_\_\_  
(Address)

\_\_\_\_\_  
(City, State, Zip Code)

SUBJECT:

\_\_\_\_\_  
(Patient Name)

\_\_\_\_\_  
(Social Security Number) (Bed Reservation Days Available)

☐

This is to notify you that the above referenced resident is temporarily absent from this facility beginning \_\_\_\_\_ and is temporarily residing in \_\_\_\_\_ psychiatric care facility.

☐

This is to notify you that the above referenced resident was officially re-admitted to this facility on \_\_\_\_\_ from \_\_\_\_\_ psychiatric care facility.

☐

This is to notify you that the above referenced resident was officially discharged from this facility on \_\_\_\_\_ and is now residing at \_\_\_\_\_.

I certify that the above information is correct and true.

I understand that it is my responsibility to notify the Department for Community Based Services within 3 days of any changes regarding the temporary absence or discharge of a psychiatric residential treatment facility patient.

I understand that I may be subject to prosecution for fraud if I provide false information or fail to report changes within the appropriate time frame regarding the temporary absence or discharge of a psychiatric residential treatment facility service patient.

\_\_\_\_\_  
(Signature)

\_\_\_\_\_  
(Title) (Date)

---

## **8.2 Billing Leave Of Absence (LOA) Days**

Following are examples for billing leave of absence (LOA) days. Leave of absence days are billed separately from days the resident was actually in the facility. A separate billing form is required for each different applicable accommodation revenue code.

The following examples illustrate proper billing procedures on the UB-04 billing form. Billing examples for residents with leave of absence days are illustrated below.

### **Example #1**

The resident is admitted to the facility on 06/01/10 and stays until leaving for Acute Care Hospital stay on 06/15/10. Member returns to residential facility on 06/21/10 and remains through the end of the month.

#### **First Claim:**

Type of bill 812, patient status 30, statement covers 06/01/10 - 06/14/10, 14 days covered in Form Locator 7, 14 days in Form Locator 46 and 124 in Form Locator 42.

#### **Second Claim:**

Type of bill 813, patient status 30, statement covers 06/15/10 - 06/20/10, six days covered in Form Locator 7, six days in Form Locator 46 and 185 in Form Locator 42.

#### **Third Claim:**

Type of bill 813, patient status code 30, statement covers 06/21/10 - 06/30/10, 10 days covered in Form Locator 7, 10 days in Form Locator 46 and 124 in Form Locator 42.

### **Example #2**

The resident is in facility on 07/01/10, is admitted to a mental hospital on 7/10/10, and returns to the facility on 07/21/10 for the remainder of the month.

#### **First Claim:**

Type of bill 813, patient status 30, statement covers 07/01/10 - 07/10/10, 10 days covered in Form Locator 7, 10 days in Form Locator 46 and 124 in Form Locator 42.

#### **Second Claim:**

Type of bill 813, patient status 30, statement covers 07/11/10 - 07/20/10, 10 days covered in Form Locator 7, 10 days in Form Locator 46 and 180 in Form Locator 42.

#### **Third Claim:**

Type of bill 813, patient status 30, and statement covers 07/21/10 - 07/31/10, 11 days covered in Form Locator 7, 11 days in Form Locator 46 and 124 in Form Locator 42.

---

### **Example #3**

The Member of the facility leaves the facility on 08/11/10, is admitted to a psychiatric bed in an acute hospital for seven days, and returns to facility on 08/18/10 for the remainder of the month.

#### **First Claim:**

Type of bill, patient status code 30, statement covers 08/01/10 - 08/10/10, 10 days covered in Form Locator 7, 10 days in Form Locator 46 and 124 in Form Locator 42.

#### **Second Claim:**

Type of bill 813, patient status code 30, and statement covers 08/11/10 - 08/17/10, seven days covered in Form Locator 7, seven days in Form Locator 46 and 183 in Form Locator 42.

#### **Third Claim:**

Type of bill 813, patient status code 30, statement covers 08/18/10 - 08/31/10, 14 days covered in Form Locator 7, 14 days in Form Locator 46 and 124 in Form Locator 42.

### **Example #4**

The Member leaves for a home visit of 14 days during the month beginning on 09/11/10 through 09/24/10. The Member then returns to the facility on 09/25/10 for the remainder of the month.

#### **First Claim:**

Type of bill 813, patient status code 30, statement covers 09/01/10 - 09/10/10, 10 days covered in Form Locator 7, 10 days in Form Locator 46 and 124 in Form Locator 42.

#### **Second Claim:**

Type of bill 813, patient code 30, statement covers 09/11/10 - 09/24/10, 14 days covered in Form Locator 7, 14 days in Form Locator 46 and 182 in Form Locator 42.

#### **Third Claim:**

Type of bill 813, patient status code 30, statement covers 09/25/10 - 09/30/10, six days covered in Form Locator 7, 14 days in Form Locator 46 and 124 in Form Locator 42.

---

### **Example #5**

Resident leaves facility 10/11/10 for Acute Hospital stay for three days then returns home with his parents on 10/14/10 for seven days before going back to the facility on 10/21/10 for the remainder of the month.

#### **First Claim:**

Type of bill 813, patient status code 30, statement covers 10/01/10 - 10/10/10, 10 days covered in Form Locator 7, 10 days in Form Locator 46 and 124 in Form Locator 42.

#### **Second Claim:**

Type of bill 813, patient status code 30, statement covers 10/11/10 - 10/13/10, three days covered in Form Locator 7, three days in Form Locator 46 and 185 in Form Locator 42.

#### **Third Claim:**

Type of bill 813, patient status code 30, statement covers 10/14/10 - 10/20/10, seven days covered in Form Locator 7, seven days in Form Locator 46 and 182 in Form Locator 42.

#### **Fourth Claim:**

Type of bill 813, patient status code 30, statement covered 10/21/10 - 10/31/10, 11 days covered in Form Locator 7, 11 days in Form Locator 46 and 124 in Form Locator 42.

---

## 9 Appendix A

### 9.1 Internal Control Number (ICN)

An Internal Control Number (ICN) is assigned by HP Enterprise Services to each claim. During the imaging process a unique control number is assigned to each individual claim for identification, efficient retrieval, and tracking. The ICN consists of 13 digits and contains the following information:

**11 – 10 – 032 - 123456**

**1      2      3      4**

1. Region

<b>10</b>	PAPER CLAIMS WITH NO ATTACHMENTS
<b>11</b>	PAPER CLAIMS WITH ATTACHMENTS
<b>20</b>	ELECTRONIC CLAIMS WITH NO ATTACHMENTS
<b>21</b>	ELECTRONIC CLAIMS WITH ATTACHMENTS
<b>22</b>	INTERNET CLAIMS WITH NO ATTACHMENTS
<b>40</b>	CLAIMS CONVERTED FROM OLD MMIS
<b>45</b>	ADJUSTMENTS CONVERTED FROM OLD MMIS
<b>50</b>	ADJUSTMENTS - NON-CHECK RELATED
<b>51</b>	ADJUSTMENTS - CHECK RELATED
<b>52</b>	MASS ADJUSTMENTS - NON-CHECK RELATED
<b>53</b>	MASS ADJUSTMENTS - CHECK RELATED
<b>54</b>	MASS ADJUSTMENTS - VOID TRANSACTION
<b>55</b>	MASS ADJUSTMENTS - PROVIDER RATES
<b>56</b>	ADJUSTMENTS - VOID NON-CHECK RELATED
<b>57</b>	ADJUSTMENTS - VOID CHECK RELATED

2. Year of Receipt

3. Julian Date of Receipt (The Julian calendar numbers the days of the year 1-365. For example, 001 is January 1 and 032 (shown above) is February 1.

4. Batch Sequence Used Internally

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## 10 Appendix B

### 10.1 Remittance Advice

This section is a step-by-step guide to reading a Kentucky Medicaid Remittance Advice (RA). The following sections describe major categories related to processing/adjudicating claims. To enhance this document's usability, detailed descriptions of the fields on each page are included, reading the data from left to right, top to bottom.

#### 10.1.1 Examples Of Pages In Remittance Advice

There are several types of pages in a Remittance Advice, including separate page types for each type of claim; however, if a provider does not have activity in that particular category, those pages are not included.

Following are examples of pages which may appear in a Remittance Advice:

FIELD	DESCRIPTION
<b>Returned Claims</b>	This section lists all claims that have been returned to the provider with an RTP letter. The RTP letter explains why the claim is being returned. These claims are returned because they are missing information required for processing.
<b>Paid Claims</b>	This section lists all claims paid in the cycle.
<b>Denied Claims</b>	This section lists all claims that denied in the cycle.
<b>Claims In Process</b>	This section lists all claims that have been suspended as of the current cycle. The provider should maintain this page and compare with future Remittance Advices until all the claims listed have appeared on the PAID CLAIMS page or the DENIED CLAIMS page. Until that time, the provider need not resubmit the claims listed in this section.
<b>Adjusted Claims</b>	This section lists all claims that have been submitted and processed for adjustment or claim credit transactions.
<b>Mass Adjusted Claims</b>	This section lists all claims that have been mass adjusted at the request of the Department for Medicaid Services (DMS).
<b>Financial Transactions</b>	This section lists financial transactions with activity during the week of the payment cycle.
	<b>NOTE: It is imperative the provider maintains any A/R page with an outstanding balance.</b>



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<b>Summary</b>	This section details all categories contained in the Remittance Advice for the current cycle, month to date, and year to date. Explanation of Benefit (EOB) codes listed throughout the Remittance Advice is defined in this section.
<b>EOB Code Descriptions</b>	Any Explanation of Benefit Codes (EOB) which appear in the RA are defined in this section.

**NOTE:** For the purposes of reconciliation of claims payments and claims resubmission of denied claims, it is highly recommended that all remittance advices be kept for at least one year.

---

## 10.2 Title

The header information that follows is contained on every page of the Remittance Advice.

REPORT: CRA-XBPD-R  
RA#: 9999999

COMMONWEALTH OF KENTUCKY (M1)  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
PROVIDER REMITTANCE ADVICE

DATE: 01/25/2007  
PAGE: 2

FIELD	DESCRIPTION
DATE	The date the Remittance Advice was printed.
RA NUMBER	A system generated number for the Remittance Advice.
PAGE	The number of the page within each Remittance Advice.
CLAIM TYPE	The type of claims listed on the Remittance Advice.
PROVIDER NAME	The name of the provider that billed. (The type of provider is listed directly below the name of provider.)
PAYEE ID	The eight-digit Medicaid assigned provider ID of the billing provider.
NPI ID	The NPI number of the billing provider.

The category (type of page) begins each section and is centered (for example, \*PAID CLAIMS\*). All claims contained in each Remittance Advice are listed in numerical order of the prescription number.

## 10.3 Banner Page

All Remittance Advices have a “banner page” as the first page. The “banner page” contains provider specific information regarding upcoming meetings and workshops, “top ten” billing errors, policy updates, billing changes etc. Please pay close attention to this page.

REPORT: CRA-BANN-R  
RA#: 9999999

COMMONWEALTH OF KENTUCKY (M1)  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
PROVIDER REMITTANCE ADVICE  
PROVIDER BANNER MESSAGES

DATE: 01/23/2007  
PAGE: 1

PROVIDER  
555 ANY STREET  
CITY, KY 55555-0000

PAYEE ID 99999999  
NPI ID 99999999  
CHECK/EFT NUMBER 99999999  
ISSUE DATE 01/26/2007

Commonwealth of Kentucky

REPORT: CRA-IPPD-R  
RA#: 9999999

COMMONWEALTH OF KENTUCKY (M1)  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
PROVIDER REMITTANCE ADVICE  
UB CLAIMS PAID

DATE: 01/30/2007  
PAGE: 2

PROVIDER  
5555 ANY STREET  
CITY, KY 55555-5555

PAYEE ID 99999999  
NPI ID  
CHECK/EFT NUMBER 999999999  
ISSUE DATE 02/02/2007

--ICN--	ATTENDING PROV.	SERVICE DATES	DAYS	ADMIT	BILLED AMT	ALLOWED AMT	SPENDDOWN	TPL AMT	PAID AMT
PAT.ACCT NUM.		FROM THRU		DATE			COPAY AMT		
MEMBER NAME: JANE DOE		MEMBER NO.: MBRID99999							
ICN9999999999	NPI9999999	030806 031006	2	030806	6,307.35	0.00	0.00	0.00	3,488.25
PATACCT 9999999999							0.00		

HEADER EOBS: 9932 00A2

REV CD	HCPCS/RATE	SRV DATE	LVL CARE	UNITS	BILLED AMT	ALLOWED AMT	DETAIL EOBS
120		030806	DEF	2.00	1,700.00	0.00	2527 0062 0883 0018
250		030806	DEF	48.00	653.90	0.00	9932 0018
258		030806	DEF	7.00	275.30	0.00	9932 0018
270		030806	DEF	67.00	386.15	0.00	9932 0018
300		030806	DEF	12.00	292.00	0.00	9932 0018
310		030806	DEF	3.00	177.00	0.00	9932 0018
360		030806	DEF	1.00	2,148.00	0.00	9932 0018
370		030806	DEF	1.00	299.00	0.00	9932 0018
710		030806	DEF	1.00	376.00	0.00	9932 0018

MEMBER NAME: JANE DOE	MEMBER NO.: 9999999999								
9999999999999999	99999999999	030806 031006	2	030806	6,307.35	0.00	0.00	0.00	3,488.25
999999999999							0.00		

HEADER EOBS: 9932 0018

REV CD	HCPCS/RATE	SRV DATE	LVL CARE	UNITS	BILLED AMT	ALLOWED AMT	DETAIL EOBS
120		030806	DEF	2.00	1,700.00	0.00	9932 0018 0275 0015
250		030806	DEF	48.00	653.90	0.00	9932 0015 0883 00
258		030806	DEF	7.00	275.30	0.00	9932 0018
270		030806	DEF	67.00	386.15	0.00	9932 0018
300		030806	DEF	12.00	292.00	0.00	9932 0018
310		030806	DEF	3.00	177.00	0.00	9932 0018
360		030806	DEF	1.00	2,148.00	0.00	9932 0018
370		030806	DEF	1.00	299.00	0.00	9932 0018
710		030806	DEF	1.00	376.00	0.00	9932 0018

TOTAL UB CLAIMS PAID:	12,614.70	0.00	0.00	0.00	6,976.50
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## 10.4 Paid Claims Page

FIELD	DESCRIPTION
<b>PATIENT ACCOUNT</b>	The 14-digit alpha/numeric Patient Account Number from Form Locator 3.
<b>MEMBER NAME</b>	The Member's last name and first initial.
<b>MEMBER NUMBER</b>	The Member's ten-digit Identification number as it appears on the Member's Identification card.
<b>ICN</b>	The 12-digit unique system generated identification number assigned to each claim by HP Enterprise Services.
<b>ATTENDING PROVIDER</b>	The member's attending provider.
<b>CLAIM SERVICE DATES FROM – THRU</b>	The date or dates the service was provided in month, day, and year numeric format.
<b>DAYS</b>	The number of days billed.
<b>ADMIT DATE</b>	The admit date of the member.
<b>BILLED AMOUNT</b>	The usual and customary charge for services provided for the Member.
<b>ALLOWED AMOUNT</b>	The allowed amount for Medicaid
<b>SPENDDOWN COPAY AMOUNT</b>	The amount collected from the member.
<b>TPL AMOUNT</b>	Amount paid, if any, by private insurance (excluding Medicaid and Medicare).
<b>PAID AMOUNT</b>	The total dollar amount reimbursed by Medicaid for the claim listed.
<b>EOB</b>	Explanation of Benefits. All EOBs detailed on the Remittance Advice are listed with a description/definition at the end of the Remittance Advice.
<b>CLAIMS PAID ON THIS RA</b>	The total number of paid claims on the Remittance Advice.
<b>TOTAL BILLED</b>	The total dollar amount billed by the provider for all claims listed on the PAID CLAIMS page of the Remittance Advice (only on final page of section).
<b>TOTAL PAID</b>	The total dollar amount paid by Medicaid for all claims listed on the PAID CLAIMS page of the Remittance Advice (only on final page of section).

REPORT: CRA-IPDN-R  
RA#: 9999999

COMMONWEALTH OF KENTUCKY (M1)  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
PROVIDER REMITTANCE ADVICE  
UB CLAIMS DENIED

DATE: 01/25/2007  
PAGE: 11

PROVIDER  
5555 ANY STREET  
SUITE 555  
CITY, KY 55555-0000

PAYEE ID 99999999  
NPI ID 99999999  
CHECK/EFT NUMBER 99999999  
ISSUE DATE 01/26/2007

--ICN--	ATTENDING PROV.	SERVICE DATES	DAYS	ADMIT	BILLED	TPL	SPENDDOWN
PATIENT ACCT.	NUM.	FROM	THRU	DATE	AMOUNT	AMOUNT	AMOUNT
MEMBER NAME: JANE DOE							
MEMBER NO.: MBRID99999							
ICN9999999999	NPI9999999	021706	022106	4	021706	10,212.66	0.00
PATACT9999							

HEADER EOBS: 2660 0092

REV CD	HCPCS/RATE	SRV DATE	LVL CARE	UNITS	BILLED AMT	DETAIL EOBS
174		021706	DEF	4.00	9,382.04	2527 0062
250		021706	DEF	3.00	15.96	9953 0062 0883 001
300		021706	DEF	5.00	355.28	9953 0018
301		021706	DEF	11.00	361.54	9953 0018
302		021706	DEF	3.00	81.42	9953 0018
306		021706	DEF	1.00	16.42	9953 0018

MEMBER NAME: JANE DOE							
MEMBER NO.: 9999999999							
999999999999	MCD 9999	021706	022106	4	021706	10,802.46	0.00
99999999							

HEADER EOBS: 2198 0016

REV CD	HCPCS/RATE	SRV DATE	LVL CARE	UNITS	BILLED AMT	DETAIL EOBS
111		021706	DEF	3.00	1,805.40	
112		021706	DEF	1.00	601.80	
250		021706	DEF	232.00	608.33	
258		021706	DEF	27.00	122.17	
272		021706	DEF	1.00	206.78	
300		021706	DEF	6.00	374.96	
301		021706	DEF	29.00	909.72	
307		021706	DEF	2.00	50.45	
312		021706	DEF	3.00	582.99	
370		021706	DEF	1.00	663.54	
460		021706	DEF	1.00	15.06	
720		021706	DEF	3.00	4,549.14	
732		021706	DEF	1.00	312.12	

TOTAL UB CLAIMS DENIED: 21,015.12 200.00 0.00

### 10.5 Denied Claims Page

<b>FIELD</b>	<b>DESCRIPTION</b>
<b>PATIENT ACCOUNT</b>	The 14-digit alpha/numeric Patient Control Number from Form Locator 3.
<b>MEMBER NAME</b>	The Member's last name and first initial.
<b>MEMBER NUMBER</b>	The Member's ten-digit Identification number as it appears on the Member's Identification card.
<b>ICN</b>	The 12-digit unique system generated identification number assigned to each claim by HP Enterprise Services.
<b>ATTENDING PROVIDER</b>	The member's attending provider.
<b>CLAIM SERVICE DATE FROM – THRU</b>	The date or dates the service was provided in month, day, and year numeric format.
<b>DAYS</b>	The number of days billed.
<b>ADMIT DATE</b>	The admit date of the member.
<b>BILLED AMOUNT</b>	The usual and customary charge for services provided for the Member.
<b>TPL AMOUNT</b>	Amount paid, if any, by private insurance (excluding Medicaid and Medicare).
<b>SPENDDOWN AMOUNT</b>	The amount owed from the member.
<b>CLAIM PMT. AMT.</b>	The total dollar amount reimbursed by Medicaid for the claim listed.
<b>EOB</b>	Explanation of Benefits. All EOBs detailed on the Remittance Advice are listed with a description/definition at the end of the Remittance Advice.
<b>CLAIMS DENIED ON THIS RA</b>	The total number of denied claims on the Remittance Advice.
<b>TOTAL BILLED</b>	The total dollar amount billed by the Home Health Services for all claims listed on the DENIED CLAIMS page of the Remittance Advice (only on final page of section).
<b>TOTAL PAID</b>	The total dollar amount paid by Medicaid for all claims listed on the DENIED CLAIMS page of the Remittance Advice (only on final page of section).

REPORT: CRA-IPSU-R  
RA#: 9999999

COMMONWEALTH OF KENTUCKY (M1)  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
PROVIDER REMITTANCE ADVICE  
UB CLAIMS IN PROCESS

DATE: 01/25/2007  
PAGE: 17

PROVIDER  
5555 ANY STREET  
SUITE 555  
CITY, KY 55555-0000

PAYEE ID 99999999  
NPI ID 99999999  
CHECK/EFT NUMBER 99999999  
ISSUE DATE 01/26/2007

--ICN--	ATTENDING	SERVICE DATES	DAYS	ADMIT	BILLED	TPL	SPENDDOWN
PATIENT ACCT. NUM.	PROV.	FROM	THRU	DATE	AMOUNT	AMOUNT	AMOUNT
MEMBER NAME: JOHN DOE		MEMBER NO.: MBRID99999					
ICN9999999999	NPI99999999	062206	062406	2	062206	4,010.60	0.00
PATACT9999							

REV CD	HCPCS/RATE	SRV DATE	LVL CARE	UNITS	BILLED AMT	DETAIL	EOBS
111		062206	DEF	2.00	1,203.60		
250		062206	DEF	42.00	587.84		
258		062206	DEF	22.00	455.82		
272		062206	DEF	1.00	9.01		
370		062206	DEF	1.00	774.12		
410		062206	DEF	6.00	387.76		
710		062206	DEF	1.00	592.45		

TOTAL UB CLAIMS IN PROCESS:	4010.60	0.00	0.00
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**10.6 Claims In Process Page**

<b>FIELD</b>	<b>DESCRIPTION</b>
<b>PATIENT ACCOUNT</b>	The 14-digit alpha/numeric Patient Control Number from Form Locator 3.
<b>MEMBER NAME</b>	The Member's last name and first initial.
<b>MEMBER NUMBER</b>	The Member's ten-digit Identification number as it appears on the Member's Identification card.
<b>ICN</b>	The 13-digit unique system-generated identification number assigned to each claim by HP Enterprise Services.
<b>ATTENDING PROVIDER</b>	The attending provider's NPI.
<b>CLAIM SERVICE DATE FROM – THRU</b>	The date or dates the service was provided in month, day, and year numeric format.
<b>DAYS</b>	The number of days billed.
<b>ADMIT DATE</b>	The admit date of member.
<b>BILLED AMOUNT</b>	The usual and customary charge for services provided for the Member.
<b>TPL AMOUNT</b>	Amount paid, if any, by private insurance (excluding Medicaid and Medicare).
<b>SPENDDOWN AMOUNT</b>	The amount owed from the member.

REPORT: CRA-IPPD-R  
RA#: 9999999

COMMONWEALTH OF KENTUCKY (M1)  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
PROVIDER REMITTANCE ADVICE  
UB CLAIMS RETURNED

DATE: 01/30/2007  
PAGE: 2

PROVIDER  
5555 ANY STREET  
CITY, KY 55555-5555

PAYEE ID 99999999  
NPI ID  
CHECK/EFT NUMBER 999999999  
ISSUE DATE 02/02/2007

--ICN-- REASON CODE  
999999999999 01

CLAIMS RETURNED: 01

**10.7 Returned Claim**

<b>FIELD</b>	<b>DESCRIPTION</b>
<b>ICN</b>	The 13-digit unique system generated identification number assigned to each claim by HP Enterprise Services.
<b>REASON CODE</b>	A code denoting the reason for returning the claim.
<b>CLAIMS RETURNED ON THIS RA</b>	The total number of returned claims on the Remittance Advice.

**Note:** Claims appearing on the “returned claim” page are forthcoming in the mail. The actual claim is returned with a “return to provider” sheet attached, indicating the reason for the claim being returned.

REPORT: CRA-HHAD-R  
RA#: 9999999

COMMONWEALTH OF KENTUCKY (M1)  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
PROVIDER REMITTANCE ADVICE  
UB CLAIM ADJUSTMENTS

DATE: 01/23/2007  
PAGE: 33

PROVIDER  
55555 ANY STREET  
CITY, KY 55555-0000

PAYEE ID 99999999  
NPI ID

--ICN--	ATTEND PROV.	SERVICE DATES	BILLED	ALLOWED	TPL	CO-PAY	SPENDDOWN	PAID
--PATIENT NUMBER--		FROM THRU	AMOUNT	AMOUNT	AMOUNT	AMOUNT	AMOUNT	AMOUNT
MEMBER NAME: JOHN DOE		MEMBER NO.: 9999999999						
99999999999999	MCD 9999	030106 033106	(3,886.47)	(0.00)	(0.00)	(0.00)	(0.00)	(3,592.90)
99999999999999								
99999999999999	MCD 9999	030106 033106	3,886.47	0.00	0.00	0.00	0.00	0.00
99999999999999								

HEADER EOBS: 0053 00A1

REV CD	HCPCS/RATE	SRV DATE	MODIFIERS	UNITS	BILLED AMT	ALLOWED AMT	DETAIL EOBS
651		030106		31.00	3,886.47	0.00	0686 0119
NET OVERPAYMENT (AR)							3,592.90

TOTAL NO. OF ADJ:	1						
TOTAL UB ADJUSTMENT CLAIMS:		0.00		0.00		0.00	-3,592.90

Providers have an option of requesting an adjustment, as indicated above; or requesting a cash refund (form and instructions for completion can be found in the Billing Instructions).

If a cash refund is submitted, an adjustment **CANNOT** be filed.

If an adjustment is submitted, a cash refund **CANNOT** be filed.

## 10.8 Adjusted Claims Page

The information on this page reads left to right and does not follow the general headings.

<b>FIELD</b>	<b>DESCRIPTION</b>
<b>PATIENT ACCOUNT</b>	The 14-digit alpha/numeric Patient Control Number from Form Locator 3.
<b>MEMBER NAME</b>	The Member's last name and first initial.
<b>MEMBER NUMBER</b>	The Member's ten-digit Identification number as it appears on the Member's Identification card.
<b>ICN</b>	The 12-digit unique system generated identification number assigned to each claim by HP Enterprise Services.
<b>CLAIM SERVICE DATES FROM – THRU</b>	The date or dates the service was provided in month, day, and year numeric format.
<b>BILLED AMOUNT</b>	The usual and customary charge for services provided for the Member.
<b>ALLOWED AMOUNT</b>	The amount allowed for this service.
<b>TPL AMOUNT</b>	Amount paid, if any, by private insurance (excluding Medicaid and Medicare).
<b>COPAY AMOUNT</b>	Copay amount to be collected from member.
<b>SPENDDOWN AMOUNT</b>	The amount to be collected from the member.
<b>PAID AMOUNT</b>	The total dollar amount reimbursed by Medicaid for the claim listed.
<b>EOB</b>	Explanation of Benefits. All EOBs detailed on the Remittance Advice are listed with a description/definition at the end of the Remittance Advice.
<b>PAID AMOUNT</b>	Amount paid.

**Note:** The ORIGINAL claim information appears first, followed by the NEW (adjusted) claim information.

REPORT: CRA-TRAN-R  
RA#: 9999999

COMMONWEALTH OF KENTUCKY  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
PROVIDER REMITTANCE ADVICE  
FINANCIAL TRANSACTIONS

DATE: 12/26/2006  
PAGE: 2

PROVIDER J  
PO BOX 5555  
CITY, KY 55555-5555

PAYEE ID 99999999  
NPI ID 99999999

-----NON-CLAIM SPECIFIC PAYOUTS TO PROVIDERS-----

TRANSACTION NUMBER	--CCN--	PAYOUT --AMOUNT--	REASON CODE	RENDERING PROVIDER	SVC DATE FROM THRU	MEMBER NO.	MEMBER NAME
-----------------------	---------	----------------------	----------------	-----------------------	-----------------------	------------	-------------

NO NON-CLAIM SPECIFIC PAYOUTS TO PROVIDERS

-----NON-CLAIM SPECIFIC REFUNDS FROM PROVIDERS-----

--CCN--	REFUND --AMOUNT--	REASON CODE	MEMBER NO.	MEMBER NAME
---------	----------------------	----------------	------------	-------------

NO NON-CLAIM SPECIFIC REFUNDS FROM PROVIDERS

-----ACCOUNTS RECEIVABLE-----

A/R NUMBER/ICN	SETUP DATE	RECOUPED THIS CYCLE	ORIGINAL AMOUNT	TOTAL -RECOUPED-	--BALANCE--	REASON CODE
1106	011306	0.00	22.41	0.00	22.41	92
TOTAL BALANCE						22.41

## 10.9 Financial Transaction Page

### 10.9.1 Non-Claim Specific Payouts To Providers

FIELD	DESCRIPTION
TRANSACTION NUMBER	The tracking number assigned to each financial transaction.
CCN	The cash control number assigned to refund checks for tracking purposes.
PAYMENT AMOUNT	The amount paid to the provider when the financial reason code indicates money is owed to the provider.
REASON CODE	Payment reason code.
RENDERING PROVIDER	Rendering provider of service.
SERVICE DATES	The From and Through dates of service.
MEMBER NUMBER	The KY Medicaid member identification number.
MEMBER NAME	The KY Medicaid member name.

### 10.9.2 Non-Claim Specific Refunds From Providers

FIELD	DESCRIPTION
CCN	The cash control tracking number assigned to refund checks for tracking purposes.
REFUND AMOUNT	The amount refunded by provider.
REASON CODE	The two byte reason code specifying the reason for the refund.
MEMBER NUMBER	The KY Medicaid member identification number.
MEMBER NAME	The KY Medicaid member name.

**10.9.3 Accounts Receivable**

<b>FIELD</b>	<b>DESCRIPTION</b>
<b>A / R NUBMER / ICN</b>	This is the 13-digit Internal Control Number used to identify records for one accounts receivable transaction.
<b>SETUP DATE</b>	The date entered on the accounts receivable transaction in the MM/DD/CCYY format. This date identifies the beginning of the accounts receivable event.
<b>RECOUPED THIS CYCLE</b>	The amount of money recouped on this financial cycle.
<b>ORIGINAL AMOUNT</b>	The original accounts receivable transaction amount owed by the provider.
<b>TOTAL RECOUPED</b>	This amount is the total of the providers checks and recoupment amounts posted to this accounts receivable transaction.
<b>BALANCE</b>	The system generated balance remaining on the accounts receivable transaction.
<b>REASON CODE</b>	A two-byte alpha/numeric code specifying the reason an accounts receivable was processed against a providers account.

ANY RECOUPMENT ACTIVITY OR PAYMENTS RECEIVED FROM THE PROVIDER list below the "RECOUPMENT PAYMENT SCHEDULE." All initial accounts receivable allow 60 days from the "setup date" to make payment on the accounts receivable. After 60 days, if the accounts receivable has not been satisfied nor a payment plan initiated, monies are recouped from the provider on each Remittance Advice until satisfied.

**This is your only notification of an accounts receivable setup. Please keep all Accounts Receivable Summary pages until all monies have been satisfied.**



REPORT: CRA-SUMM-R  
RA#: 9999999

COMMONWEALTH OF KENTUCKY (M1)  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
PROVIDER REMITTANCE ADVICE  
SUMMARY

DATE: 02/01/2007  
PAGE: 13

PROVIDER  
  
P O BOX 555  
CITY, KY 55555-0000

PAYEE ID 99999999  
NPI ID  
CHECK/EFT NUMBER 999999999  
ISSUE DATE 02/02/2007

-----CLAIMS DATA-----

	CURRENT NUMBER	CURRENT AMOUNT	MONTH-TD NUMBER	MONTH-TD AMOUNT	YEAR-TD NUMBER	YEAR-TD AMOUNT
CLAIMS PAID	43	130,784.46	43	130,784.46	1,988	4,143,010.13
CLAIM ADJUSTMENTS	0	0.00	0	0.00	18	0.00
MASS ADJUSTMENTS	0	0.00	0	0.00	0	0.00
TOTAL CLAIMS PAYMENTS	43	130,784.46	43	130,784.46	2,006	4,143,010.13
CLAIMS DENIED	1		1		917	
CLAIMS IN PROCESS	2					

-----EARNINGS DATA-----

PAYMENTS:

CLAIMS PAYMENTS	130,784.46	130,784.46	4,143,010.13
SYSTEM PAYOUTS (NON-CLAIM SPECIFIC)	0.00	0.00	0.00
ACCOUNTS RECEIVABLE (OFFSETS):			
CLAIM SPECIFIC:			
CURRENT CYCLE	(0.00)	(0.00)	(0.00)
OUTSTANDING FROM PREVIOUS CYCLES	(0.00)	(0.00)	(44,474.35)
NON-CLAIM SPECIFIC OFFSETS	(0.00)	(0.00)	(0.00)
NET PAYMENT	130,784.46	130,784.46	4,098,535.78

REFUNDS:

CLAIM SPECIFIC ADJUSTMENT REFUNDS	(0.00)	(0.00)	(0.00)
NON-CLAIM SPECIFIC REFUNDS	(0.00)	(0.00)	(0.00)

OTHER FINANCIAL:

MANUAL PAYOUTS (NON-CLAIM SPECIFIC)	0.00	0.00	0.00
VOIDS	(0.00)	(0.00)	(0.00)

NET EARNINGS	130,784.46	130,784.46	4,098,535.78
--------------	------------	------------	--------------

REPORT: CRA-EOBM-R  
RA#: 9999999

COMMONWEALTH OF KENTUCKY (M1)  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
PROVIDER REMITTANCE ADVICE  
EOB CODE DESCRIPTIONS

DATE: 02/01/2007  
PAGE: 14

PROVIDER  
  
P O BOX 555  
CITY, KY 55555-0000

PAYEE ID 99999999  
NPI ID  
CHECK/EFT NUMBER 999999999  
ISSUE DATE 02/02/2007

EOB CODE EOB CODE DESCRIPTION

0022 COVERED DAYS ARE NOT EQUAL TO ACCOMMODATION UNITS.  
0271 CLAIM DENIED. MEMBER AVAILABLE INCOME INFORMATION NOT ON FILE FOR THE MONTH OF SERVICE. PLEASE  
CONTACT DMS AT 502-564-6885.  
0409 INVALID PROVIDER TYPE BILLED ON CLAIM FORM.  
0883 CLAIM DENIED. DEPLICATE PROCEDURE HAS BEEN PAID.  
9999 PROCESSED PER MEDICAID POLICY

HIPAA REASON CODE HIPAA ADJ REASON CODE DESCRIPTION

0016 Claim/service lacks information which is needed for adjudication. Additional information is supplied  
using remittance advice remarks codes whenever appropriate  
0018 Duplicate claim/service.  
0052 The referring/prescribing/rendering provider is not eligible to refer/prescribe/order/perform the  
service billed.  
0092 Claim Paid in full.  
00A1 Claim denied charges.

**10.10 Summary Page**

<b>FIELD</b>	<b>DESCRIPTION</b>
<b>CLAIMS PAID</b>	The number of paid claims processed, current month and year to date.
<b>CLAIM ADJUSTMENTS</b>	The number of adjusted/credited claims processed, adjusted/credited amount billed, and adjusted/credited amount paid or recouped by Medicaid. If money is recouped, the dollar amount is followed by a negative (-) sign. These figures correspond with the summary of the last page of the ADJUSTED CLAIMS section.
<b>PAID MASS ADJ CLAIMS</b>	<p>The number of mass adjusted/credited claims, mass adjusted/credited amount billed, and mass adjusted/credited amount paid or recouped by Medicaid. These figures correspond with the summary line of the last page of the MASS ADJUSTED CLAIMS section.</p> <p>Mass Adjustments are initiated by Medicaid and HP Enterprise Services for issues that affect a large number of claims or providers. These adjustments have their own section "MASS ADJUSTED CLAIMS" page, but are formatted the same as the ADJUSTED CLAIMS page.</p>
<b>CLAIMS DENIED</b>	These figures correspond with the summary line of the last page of the DENIED CLAIMS section.
<b>CLAIMS IN PROCESS</b>	The number of claims processed that suspended along with the amount billed of the suspended claims. These figures correspond with the summary line of the last page of the CLAIMS IN PROCESS section.

**10.10.1 Payments**

<b>FIELD</b>	<b>DESCRIPTION</b>
<b>CLAIMS PAYMENT</b>	The number of claims paid.
<b>SYSTEM PAYOUTS</b>	Any money owed to providers.
<b>NET PAYMENT</b>	Net payment amount.
<b>REFUNDS</b>	Any money refunded to Medicaid by a provider.
<b>OTHER FINANCIAL</b>	
<b>NET EARNINGS</b>	Total check amount.

**EXPLANATION OF BENEFITS**

<b>FIELD</b>	<b>DESCRIPTION</b>
<b>EOB</b>	A five-digit number denoting the EXPLANATION OF BENEFITS detailed on the Remittance Advice.
<b>EOB CODE DESCRIPTION</b>	Description of the EOB Code. All EOB Codes detailed on the Remittance Advice are listed with a description/ definition.
<b>COUNT</b>	Total number of times an EOB Code is detailed on the Remittance Advice.

**EXPLANATION OF REMARKS**

<b>FIELD</b>	<b>DESCRIPTION</b>
<b>REMARK</b>	A five-digit number denoting the remark identified on the Remittance Advice.
<b>REMARK CODE DESCRIPTION</b>	Description of the Remark Code. All remark codes detailed on the Remittance Advice are listed with a description/definition.
<b>COUNT</b>	Total number of times a Remark Code is detailed on the Remittance Advice.

**EXPLANATION OF ADJUSTMENT CODE**

<b>FIELD</b>	<b>DESCRIPTION</b>
<b>ADJUSTMENT CODE</b>	A two-digit number denoting the reason for returning the claim.
<b>ADJUSTMENT CODE DESCRIPTION</b>	Description of the adjustment Code. All adjustment codes detailed on the Remittance Advice are listed with a description/definition.
<b>COUNT</b>	Total number of times an adjustment Code is detailed on the Remittance Advice.

**EXPLANATION OF RTP CODES**

<b>FIELD</b>	<b>DESCRIPTION</b>
<b>RTP CODE</b>	A two-digit number denoting the reason for returning the claim.
<b>RETURN CODE DESCRIPTION</b>	Description of the RTP Code. All RTP codes detailed on the Remittance Advice are listed with a description/ definition.
<b>COUNT</b>	Total number of times an RTP Code is detailed on the Remittance Advice.

## 11 Appendix C

### 11.1 Remittance Advice Location Codes (LOC CD)

The following is a code indicating the Department for Medicaid Services branch/division or other agency that originated the Accounts Receivable:

A	Active
B	Hold Recoup - Payment Plan Under Consideration
C	Hold Recoup - Other
D	Other-Inactive-FFP-Not Reclaimed
E	Other – Inactive - FFP
F	Paid in Full
H	Payout on Hold
I	Involves Interest – Cannot Be Recouped
J	Hold Recoup Refund
K	Inactive-Charge off – FFP Not Reclaimed
P	Payout – Complete
Q	Payout – Set Up In Error
S	Active - Prov End Dated
T	Active Provider A/R Transfer
U	HP Enterprise Services On Hold
W	Hold Recoup - Further Review
X	Hold Recoup - Bankruptcy
Y	Hold Recoup - Appeal
Z	Hold Recoup - Resolution Hearing

## 12 Appendix D

### 12.1 Remittance Advice Reason Code (ADJ RSN CD or RSN CD)

The following is a two-byte alpha/numeric code specifying the reason an accounts receivable was processed against a provider's account:



01	Prov Refund – Health Insur Paid	32	Payout – Advance to be Recouped
02	Prov Refund – Member/Rel Paid	33	Payout – Error on Refund
03	Prov Refund – Casualty Insu Paid	34	Payout – RTP
04	Prov Refund – Paid Wrong Vender	35	Payout – Cost Settlement
05	Prov Refund – Apply to Acct Recv	36	Payout – Other
06	Prov Refund – Processing Error	37	Payout – Medicare Paid TPL
07	Prov Refund-Billing Error	38	Recoupment – Medicare Paid TPL
08	Prov Refund – Fraud	39	Recoupment – DEDCO
09	Prov Refund – Abuse	40	Provider Refund – Other TLP Rsn
10	Prov Refund – Duplicate Payment	41	Acct Recv – Patient Assessment
11	Prov Refund – Cost Settlement	42	Acct Recv – Orthodontic Fee
12	Prov Refund – Other/Unknown	43	Acct Receivable – KENPAC
13	Acct Receivable – Fraud	44	Acct Recv – Other DMS Branch
14	Acct Receivable – Abuse	45	Acct Receivable – Other
15	Acct Receivable – TPL	46	Acct Receivable – CDR-HOSP-Audit
16	Acct Recv – Cost Settlement	47	Act Rec – Demand Paymt Updt 1099
17	Acct Receivable – HP Enterprise Services Request	48	Act Rec – Demand Paymt No 1099
18	Recoupment – Warrant Refund	49	PCG
19	Act Receivable-SURS Other	50	Recoupment – Cold Check
20	Acct Receivable – Dup Payt	51	Recoupment – Program Integrity Post Payment Review Contractor A
21	Recoupment – Fraud	52	Recoupment – Program Integrity Post Payment Review Contractor B
22	Civil Money Penalty	53	Claim Credit Balance
23	Recoupment – Health Insur TPL	54	Recoupment – Other St Branch
24	Recoupment – Casualty Insur TPL	55	Recoupment – Other
25	Recoupment – Member Paid TPL	56	Recoupment – TPL Contractor
26	Recoupment – Processing Error	57	Acct Recv – Advance Payment
27	Recoupment – Billing Error	58	Recoupment – Advance Payment
28	Recoupment – Cost Settlement	59	Non Claim Related Overage
29	Recoupment – Duplicate Payment	60	Provider Initiated Adjustment
30	Recoupment – Paid Wrong Vendor	61	Provider Initiated CLM Credit
31	Recoupment – SURS		

62	CLM CR-Paid Medicaid VS Xover	95	Beginning Recoupment Balance
63	CLM CR-Paid Xover VS Medicaid	96	Ending Recoupment Balance
64	CLM CR-Paid Inpatient VS Outp	97	Begin Dummy Rec Bal
65	CLM CR-Paid Outpatient VS Inp	98	End Dummy Recoup Balance
66	CLS Credit-Prov Number Changed	99	Drug Unit Dose Adjustment
67	TPL CLM Not Found on History	AA	PCG 2 Part A Recoveries
68	FIN CLM Not Found on History	BB	PCG 2 Part B Recoveries
69	Payout-Withhold Release	CB	PCG 2 AR CDR Hosp
71	Withhold-Encounter Data Unacceptable	DG	DRG Retro Review
72	Overage .99 or Less	DR	Deceased Member Recoupment
73	No Medicaid/Partnership Enrollment	IP	Impact Plus
74	Withhold-Provider Data Unacceptable	IR	Interest Payment
75	Withhold-PCP Data Unacceptable	CC	Converted Claim Credit Balance
76	Withhold-Other	MS	Prog Intre Post Pay Rev Cont C
77	A/R Member IPV	OR	On Demand Recoupment Refund
78	CAP Adjustment-Other	RP	Recoupment Payout
79	Member Not Eligible for DOS	RR	Recoupment Refund
80	Adhoc Adjustment Request	SS	State Share Only
81	Adj Due to System Corrections	UA	HP Enterprise Services Medicare Part A Recoup
82	Converted Adjustment	XO	Reg. Psych. Crossover Refund
83	Mass Adj Warr Refund		
84	DMS Mass Adj Request		
85	Mass Adj SURS Request		
86	Third Party Paid – TPL		
87	Claim Adjustment – TPL		
88	Beginning Dummy Recoupment Bal		
89	Ending Dummy Recoupment Bal		
90	Retro Rate Mass Adj		
91	Beginning Credit Balance		
92	Ending Credit Balance		
93	Beginning Dummy Credit Balance		
94	Ending Dummy Credit Balance		

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## 13 Appendix E

### 13.1 Remittance Advice Status Code (ST CD)

The following is a one-character code indicating the status of the accounts receivable transaction:

A	Active
B	Hold Recoup - Payment Plan Under Consideration
C	Hold Recoup - Other
D	Other-Inactive-FFP-Not Reclaimed
E	Other – Inactive - FFP
F	Paid in Full
H	Payout on Hold
I	Involves Interest – Cannot Be Recouped
J	Hold Recoup Refund
K	Inactive-Charge off – FFP Not Reclaimed
P	Payout – Complete
Q	Payout – Set Up In Error
S	Active - Prov End Dated
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X	Hold Recoup - Bankruptcy
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Z	Hold Recoup - Resolution Hearing